Homeless Health Needs Assessment

2023

SOMERSET

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ABBREVIATION	MEANING
A&E	Accident and Emergency
ACE	Adverse Childhood Experience
ACT	Assertive Community Treatment
ARBD	Alcohol related brain damage
B&B	Bed and breakfast
CATCH	Coordinated Access to Care for the Homeless
CLICK	Chard, Ilminster and Langport PCN
CSC	Childrens Social Care
CTI	Critical Time Intervention
CVD	Cardio Vascular disease
DLUHC	Department for Levelling Up, Housing and Communities
DNAS	Did not attend
ED	Emergency Department
GP	General Practitioner
HCV	Hepatitis C
HEP	Health Equalities Partnership
HIV	Human immunodeficiency virus
HRA	Homelessness Reduction Act
HRSNS	Homeless Rough Sleeper Nursing Service
HWBB	Health and Wellbeing Board
ICB	Integrated Care Board
ICM	Intensive Case Management
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
INHIP	Innovation for Healthcare Inequalities Programme
LSOA	Lower Layer Super Output Area
MIU	Minor Injury Unit
MPH	Musgrove Park Hospital
NDTMS	National Drug Treatment Monitoring System
NFA	No fixed abode
NHS	National Health service
NICE	National Institute of Clinical Excellence
NSAP	Next Steps Accommodation Programme
OHID	Office of Health Improvement and Disparities
ONS	Office of National Statistics
P2I	Pathways to Independence
PCN	Primary Care Network
PSH	Permanent Supportive Housing
RP	Registered Provider (Housing)
RSDATG	Rough sleeping drug and alcohol treatment grant
RSI	Rough sleeping initiative
SDAS	Somerset Drug and Alcohol Service
SHAP	Single Homeless Accommodation Programme
SHMA	Strategic Housing Market Assessment
SOMERSET FT	Somerset Foundation Trust
SSAB	Somerset Safeguarding Adults Board
SWASFT	South West Ambulance Somerset Foundation Trust
SWAT	Somerset West and Taunton
TAU	Treatment as Usual
TB	Tuberculosis
TYS	Targeted Youth Support
UE	Unauthorised encampment
VCFSE	Voluntary, Community, Faith and Social Enterprise
YDH	Yeovil District Hospital

Executive Summary

Homelessness is a serious societal and complex public health issue that is an indicator of fundamental breakdown in a person's life with wide-ranging causes and consequences including ill-health. Rough sleeping is the most visible and extreme end of homelessness.

Whilst the connection between housing and homelessness is well understood, the strong link between health and homelessness is often overlooked. Poor health is a major cause of homelessness, and homelessness and rough sleeping can lead to additional health needs developing and/or exacerbate existing ones.

It is now well recognised that those experiencing homelessness often suffer multiple disadvantage, experiencing a combination of problems including substance misuse, contact with the criminal justice system and mental ill health. They often fall through the gaps between services and systems, making it harder to address their problems and lead fulfilling lives. Solutions to improve the health and wellbeing of the homeless population require both a systemwide commitment and well-coordinated local services.

For some years now Somerset has recognised that homelessness is fundamentally a health and wellbeing issue, within which housing is a major factor. There has been significant activity around system change and the health of people experiencing homelessness has been a key feature of this.

This needs assessment has been undertaken at a time when the local government structure has been reorganised into one unitary authority, the Somerset ICS has been established and two NHS trusts have come together. During this same period the homeless health approach in Somerset has been recognised nationally by both the Royal Society for Public Health (2022) and most recently at the NHS Parliamentary Awards, where Somerset won the 'Health Equities' category (2023). Despite this and within the wider context of national guidance and local system change, practitioners share that there is still much to do.

This homelessness health needs assessment is a review of both national and local data, guidance, and learning, in relation to homeless health and the wider determinants of health which impact upon it, to inform decision making around commissioning and service delivery into the future.

A needs analysis conducted in Somerset in 2015 established there were 600 individual adults in contact with The Pathways 4 Adults (P4A) service between January and December 2014 and of those 541 individuals all had either single or multiple mental health, substance misuse, offending or domestic abuse support need (P4A was a service commissioned with the primary purpose of to preventing homelessness and repeat/revolving homelessness). Needs analysis conducted in 2023, as part of the Better Futures programme in Somerset, identified that Somerset continues to have an estimated population of 600 single homeless individuals. An estimate which is echoed by other data sources.

Our analysis of local data shows that mental health, substance misuse and dual diagnosis remain the most salient health needs within this homeless population – we consider how this compares to the national picture.

We also identify wider needs around physical health, self-neglect, tri-morbidity, access to health and wellbeing services, safeguarding and the approach to deaths amongst the cohort (recording and data issues).

Key risk factors identified for this inclusion health population include; mental health, ACES/trauma, vulnerable migrants, experience of domestic abuse, sexual exploitation, the justice system and veterans.

Several System risks are then considered, which could adversely impact upon the homeless cohort including: health, wellbeing, care, provision and culture, financial pressures, approaches to planning and commissioning, accommodation and climate change.

Our literature review explores the evidence regarding which interventions and support are effective in reducing poor mental health and substance misuse in rough sleeping/homeless populations. This evidence shows that interventions and services intended to enhance resilience mechanisms and strategies are warranted in improving quality of life outcomes of this population group. It also shows that a variety of interventions can be effective in addressing substance misuse, mental health and dual diagnosis, among homeless individuals.

We finalise this needs assessment with evidence-based recommendations to help guide the development of a clear strategy for homeless health in order to secure better outcomes for the current and future homeless population, encourage prevention and improve working practices and approaches to safeguarding throughout the Somerset system.

We encourage all partners in Somerset to consider, and where relevant, to adopt these recommendations many of which are or will become part of wider national policy and guidance.

1. **ICB** to develop an overarching **Somerset Homeless People's Health strategy** to underpin the Somerset ICS's NHS Core 20 Plus commitment where homelessness has been identified as a system priority and adopt the principles for NHS Inclusion Health – once published.
2. **Accommodation and support** – Housing (Somerset Council) and Health (NHS) to collaborate with partners on the delivery of strategy, including outreach, residential provision, and a hospital pathway.
3. **Care coordination** and **continuity of care** between settings - including better access to patient data (where practitioners can view and update data which can be seen across health and care organisations).
4. **Mental Health** – system leaders and commissioners to acknowledge the scale of the findings around mental health and consider impact of this on future commissioning – e.g., Better Futures etc.
5. **Substance misuse** – Somerset Strategic Drug and Alcohol Partnership to review and develop local pathways for inpatient detoxification and residential rehabilitation and build links with housing to develop step down options to prevent homelessness after an acute episode leading to hospital admission.
6. **Health Protection** - Prevention, detection and treatment of infections related to injecting drug use - health and care partners to collaborate on improving the data around HVC, HIV, iGAS etc. to ensure coordinated and targeted activity to improve case finding and reporting and engage clients in prevention and treatment.
7. **Dental Access** – The outcomes/findings of the time limited homeless dental access pilot will need to be considered and the learning incorporated into the wider Somerset Homeless People's Health strategy to inform future approaches and funded activity.
8. **Prevention activity** – Housing, Children's Social Care and Education (School/FE) workforce development regarding the long-term impact of ACEs and trauma and the need for all practitioners to both see and act.

9. **PCN/SFT (Emergency Dept.)** mandatory education programme around inclusion health and multiple disadvantage – service leads and patient facing staff (adopt the principles for NHS Inclusion Health – once published).
10. **Adults Social Care**
    a. education programme around self-neglect, executive dysfunction and Care Act legislation – commissioners and operational staff.
    b. Need for improved data recording – e.g., housing status within Eclipse.
    c. Improved locality working
11. **Safeguarding -** Somerset Safeguarding Adults Board, Somerset Council and NHS to adopt and implement NICE Guidance NG214.
12. **Homeless mortality, Coroner, Medical Examiner** - Improved approach to recording, reviewing and understanding deaths amongst the cohort.
13. **Annual data refresh to track progress** – NHS, SWASFT, Temporary Accommodation, and coroner (as seen in this report).

Key partners who have contributed to this needs assessment, and without whom we would not have been able to consider such a broad range of data and information, include Somerset Council including Adults and Children's social care and Housing, the NHS in Somerset (ICB and Foundation Trust), Accommodation and Housing Providers, VCSFE and those responsible for the Criminal Justice system.

1 Purpose, Scope, Context

Homelessness is a serious societal and complex public health issue, which is an indicator of fundamental breakdown in a person's life, with wide-ranging causes and consequences, including ill-health.

Rough sleeping is the most visible and extreme end of homelessness and a complex issue - some people may spend a single night out whilst others experience harmful long-term rough sleeping whilst some will have returned to rough sleeping after a period away. Although the connection between housing, homelessness and rough sleeping is well understood, the strong link between health and homelessness is often overlooked. Poor health is a major cause of homelessness, and homelessness and rough sleeping can lead to additional health needs developing and/or exacerbates existing ones. It is now well recognised that those experiencing homelessness often suffer multiple disadvantage, experiencing a combination of problems including substance misuse, contact with the criminal justice system and mental ill health. They often fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.

Understanding the health of people experiencing homelessness and rough sleeping in Somerset is crucial if our understanding of how their needs differ to general population are to be improved. For example, more effort and targeted approaches are often needed to ensure that health and social care for people experiencing homelessness is available, accessible, and provided to the same standards and quality as for the general population.

The purpose of this health needs assessment is to support the NHS Core 20 Plus plan for Somerset through the systematic review of a wide range of information and data regarding the health and care needs of the homeless and vulnerably housed cohort of adults living within the county. Whilst the underlying causes of homelessness also include structural, societal, and economic factors – such as deprivation, unaffordable housing and exclusion, the focus for this Health Needs Assessment (HNA) will be to understand the complex and intersecting health needs this population experience, the key features of which being identified as **mental health, physical health, substance misuse, access to services, and tri-morbidity.**

The insights gained will also help us understand whether existing services meet the health needs of this population and any recommendations made will be used to inform future system wide strategy and decision-making in order to deliver improved access to, and engagement with, the full range health and social care services across Somerset.

Core 20 PLUS 5 is NHS England's national approach to tackling healthcare inequalities. 'Core 20' targets those within the 20% most deprived LSOAs nationally and there are 5 clinical areas identified as requiring accelerated improvement. In addition, the ICB is encouraged to identify local PLUS population groups (which could include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others).The ICB in Somerset have identified people experiencing homelessness as a 'plus' population within the NHS Core 20 PLUS 5 local plan[1]. This was agreed on 18th November 2022 the Population Health Board.

Furthermore, Department for Levelling Up Housing and Communities (DLUHC) strategy 'Ending Rough Sleeping for Good (2022)' published in September 2022 places a clear expectation that the local Integrated Care System (ICS) take account of the health and social care needs of people sleeping rough in their area.

2 Background

2.1 Homelessness:

An individual is considered homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them (and their household) or which it would be reasonable for them to continue to live in.

In the UK Homelessness and rough sleeping rose significantly from 2010 to 2017 - by 165%. In 2018 there were 69 percent more children in homeless families living in temporary accommodation than in 2010[2].

Rough Sleeping is the most acute and extreme form of homelessness. In Somerset when referring to homelessness this is primarily referring to those, predominantly single, adults and young people who are homeless or vulnerably housed (see definition below).

There are multiple legal obligations placed on local authorities in relation to housing and homelessness prevention – the primary legislation for this being The Housing Act 1996 and Homelessness Reduction Act 2017. Section 195 of the 1996 Act – the 'prevention duty' – places a duty on housing authorities to work with people who are threatened with homelessness within 56 days to help prevent them from becoming homelessness. In addition, the 2002 Homelessness Act, places a duty upon a local authority to develop a homelessness strategy and renew this every 5 years.

In 2019 the Somerset Homelessness and Rough Sleeper Strategy and Action Plan 2019 to 2023 identified 6 key priorities within the county:

The identified priorities were:

1. Provision of adequate affordable accommodation
2. The provision and effective use of temporary accommodation
3. Support the Government's commitment to combat rough sleeping.
4. Support prevention and early intervention
5. Enable specific client groups to access suitable accommodation.
6. Maintain strong working relationships across the partnership.

This strategy was informed by a previous Somerset Homelessness and Rough Sleeper Needs Assessment (2019), this can be found at: Somerset Homelessness Needs Assessment.pdf (southsomerset.gov.uk).

This previous Somerset Homeless Health Needs Assessment focused primarily on an overview of the population, with little to no focus on health outcomes and risks within this population.

This Homeless Health Needs Assessment will address this gap in understanding and then support the next general Homelessness Needs Assessment scheduled for 2024/25.

2.2 Definitions:

Rough Sleepers:

- People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments).

- People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or “bashes” which are makeshift shelters often comprised of cardboard boxes).
- The definition does not include:
    - People in hostels or shelters.
    - People in campsites or other sites used for recreational purposes or organised protest.
    - Squatters.
    - Travellers.

Off The Street Accommodation includes any placement for rough sleepers that is intended to last for 6 months or less and can include:

- Hostels
- Temporary Accommodation placements *(e.g., short term B&B or another hotel)*
- Severe weather emergency protocol placements
- Specific winter provision
- Short term options
- Hotels for respite and assessment
- Other assessment bed settings
- No second night out beds and night beds

2.3 Somerset Context:

2.3.1 Population

The population of Somerset was 571,600 (2021), an increase of around 41,600 people since 2011. This is a rise of 7.8% since 2011 and a 36.9% rise in 40 years since 1981. Somerset is a highly rural county with low levels of ethnic diversity and pockets of deprivation, particularly around more urbanised areas[3]. Similar to the trends seen nationally, the 65+ age group has seen the biggest increase in population size between 2011 and 2021, however, Somerset has an exceptionally high number of older people equating to 25% of the population[4]. The demographic makeup of our residents, in particular our ageing population has implications for our economy, services and communities.

2.3.1.1 Socioeconomic Status and Deprivation

Indices of Multiple Deprivation (IMD) (2019)[5], are a measurement of relative deprivation for small areas in England (LSOAs). The 2019 version is based on 39 indicators, across 7 domains including income, employment, crime, health, education, barriers to housing & services, and living environment. Somerset is generally better than the national average in terms of overall deprivation, however since 2015 there has been a slight shift towards greater deprivation in Somerset relative to England, especially influenced by housing quality.

47,806 people in Somerset live in one of the 20% most deprived areas in England, but 61,253 live in one of England’s 20% least deprived areas (This compares to 40,000 and 74,000 in 2015). The number of ‘highly deprived’ (within the 20% most deprived in England) neighbourhoods in Somerset increased to 29 (2019) from 25 (2015) (out of 327 LSOAs). This puts approximately 47,000 Somerset residents living in an area classified as one of the 20% most deprived in England. The higher levels of deprivation are generally found in the urban areas, such as Bridgwater, Yeovil and Highbridge, with the most deprived area of Somerset being Highbridge South West. Comparatively the least deprived area in Somerset is Sampson’s Wood in Yeovil, which falls within the 1% least deprived in England.

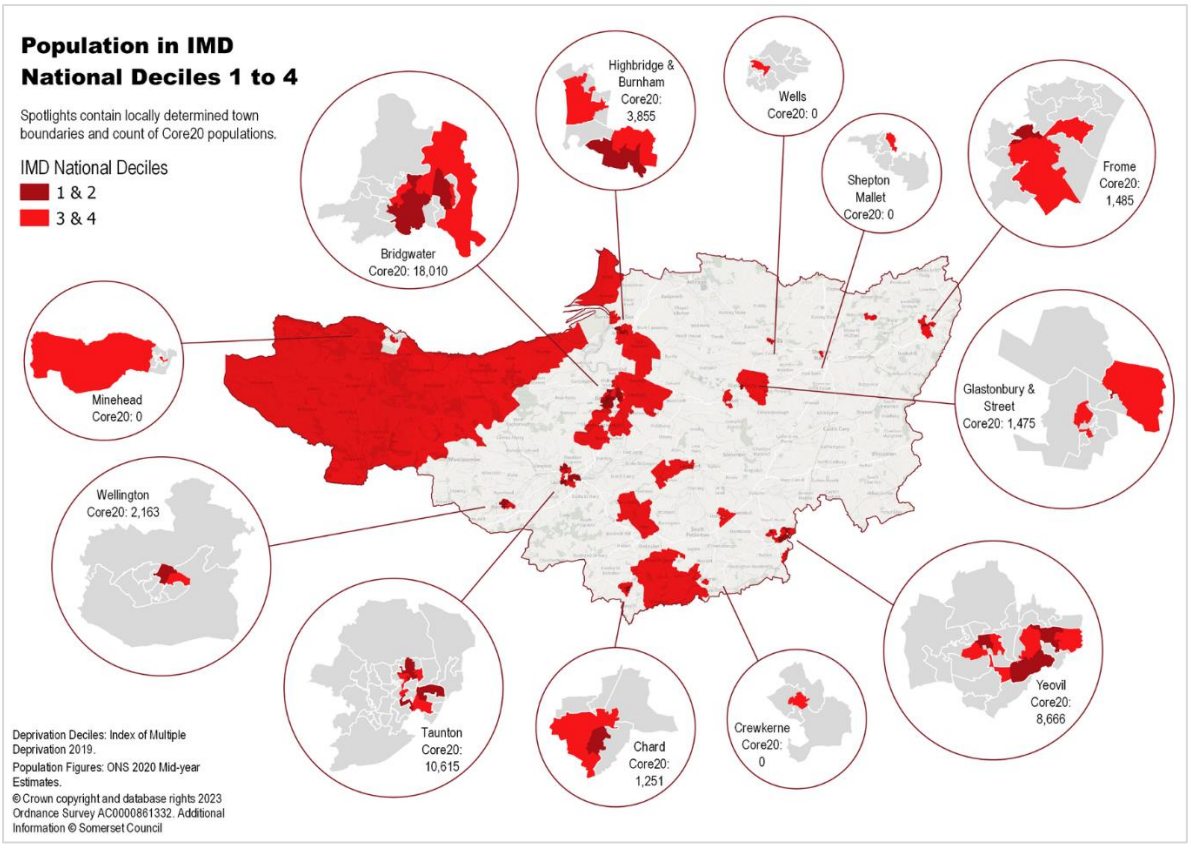

Figure 1 – National IMD deciles 1-4 (Quintiles 1&2) for Somerset by LSOA

2.3.1.2 Housing in Somerset

Somerset Strategic Housing Market Assessment 2016 (SHMA), states 'A household is considered to be able to afford to buy a home if it costs less than four times the gross household income. It is assumed that a household would have a 10% deposit'. One of the most important challenges faced by Somerset is meeting the increasing demand for housing for both private and social. This is recognised in the priorities detailed in the Somerset Strategic Housing Framework.

In particular, Priority 1 is to increase the supply of affordable housing to support economic growth and development, and Priority 2 is to make the best use of the existing housing stock.

The 2016 Strategic Housing Market Assessment for Somerset identities housing need per year up to 2039, including: number of homes required per district, the mix of homes, and the needs of different groups in the population. Key findings were that there is a need for 2,355 dwellings per year (excluding West Somerset, as this was reported as part of the Northern Peninsula – Devon, Exmoor, and West Somerset), 955 each year of which should be affordable homes, and the focus of need is for 2&3 bedroom market housing and 1&2 bedroom dwellings in the social/affordable rental sector[6].

Table 1 – The estimated size of dwellings needed for affordable housing 2014-2039 by local authority area (Source: Strategic Housing Market Assessment Somerset, 2016).

	1 Bedroom (%)	2 Bedrooms (%)	3+ Bedrooms (%)
Mendip	48.2	31.5	20.3
Sedgemoor	43.3	28.4	28.3
South Somerset	44.6	37.3	18.2
Taunton Deane	47.5	32.3	20.2

There is a significant issue in accessing affordable housing in Somerset.

This report is being prepared at a time when the UK mortgage interest rate is at its highest since 2008 and the global financial position has resulted in a cost-of-living crisis.

2.4 Homeless & Rough Sleeper Population in Somerset

2.4.1 Homelessness

The homeless and rough sleeping population is constantly changing, thus trying to assess the totality of individuals across Somerset who are sleeping rough or vulnerably housed in off street accommodation is a challenge and something which requires triangulation from several datasets to provide an estimation.

Somerset Better Futures Analysis

Better Futures Somerset focusses on the small cohort of single adults (over 16) in Somerset who have experienced multiple disadvantage and have co-existing needs e.g., people with mental ill health, drug/alcohol misuse, chaotic lifestyles and a history or risk of tenancy failure (homelessness). It aims to enable better outcomes for vulnerable people across Somerset through appropriate housing, care and support solutions. It is a system wide approach with multiple workstreams.

The Better Futures Somerset project commenced in early 2020, just before the first Covid-19 lockdown. Whilst the emergency response to the pandemic absorbed all the capacity of partner agencies initially, the collective approach adopted provided a springboard for the project, enabling artificial barriers to be removed and co-production of solutions to meet the needs of the Better Futures cohort. The project was initiated by the Somerset Strategic Housing Group, is supported by ARK Consultancy, and is now overseen by the Somerset Homelessness Reduction Board

A Better Futures needs assessment was completed in 2022 involved specialist housing providers who providing accommodation and support for the population. This included; Bournemouth Churches Housing Association, Elim Connect, Home Group, Julian House, Rethink, YMCA Dulverton Group and YMCA Brunel Group. An additional provider Arc also accommodates individuals within this cohort.

The Better Futures needs assessment data, collated in December 2022, from eight accommodation providers (seven of whom completed the needs assessment spreadsheet for a combined total of 358 residents, whilst one provider, unable to provide the full data requested, did provide data on gender, age and some support needs for the 155 people occupying their accommodation) identified **513** people using their services.

Of those 513 people accommodated in supported accommodation, 376 were male, 126 were female and 11 were reported as ‘other’ gender or unknown: roughly a 75:25 male: female split. The Rough Sleeper count data for September 2022 count identified 89 (see page 17) adults in Somerset were believed to be sleeping rough (not in supported accommodation). This enables us to estimate a population of homeless or vulnerably housed adults in Somerset as approximately **600** individuals.

NHS Community and Mental Health

The NHS in Somerset uses a database called RiO. There were 300 patients on Somerset NHS RiO database (Community and Mental Health) who were classified as Homeless at the end of January 2023. Some of whom may move into settled accommodation in February, some new people may become homeless. At the end of February, the total count was 301,

additionally in March, whilst there was some churn, there were 300 patients at the end of the month. Whilst a patient's status may change for reasons such as people having their housing status changed and moving onto accommodation and new people being updated on the system as Homeless/NFA etc. the rolling average currently for people on just RiO (Community and Mental Health) data is **300**[7].

It is reasonable to assume, based on the information regarding single adults above, that approximately 50% of the known homeless cohort are actively engaged with NHS provision at any given time.

Homelessness – households (which includes one person households) owed a duty under the Homelessness Reduction Act (HRA).

As of 2020/21 7.6 per 1,000 population (count **1,905**) in Somerset were households owed a duty under the HRA. This is significantly better than nationally (11.2 per 1,000) and regionally (11.7 per 1,000) (2021/22)[8].

Homelessness – households in temporary accommodation

Local authorities must provide temporary accommodation for households under some circumstances, these can include pending the completion of an application, or if an application has been accepted until suitable secure accommodation becomes available (2017 HRA).

In Somerset 0.3 per 1,000 (count **77**, 2021/22), are households in temporary accommodation, this is significantly better than the South West regional average of 1.6 per 1,000, and the national average of 4.0 per 1,000. This is highest in Sedgemoor at 0.6 per 1,000, then South Somerset 0.5 per 1,000, and lowest in Mendip (0.1 per 1,000), (there is no data presented for SWAT) (2021/22)[9].

More detailed information can be found at: Statutory homelessness in England: financial year 2021-22 - GOV.UK (www.gov.uk)

Chapter 17 of The Homelessness Code of Guidance for Local Authorities addresses the suitability of temporary accommodation and has specific comments in relation to families in Temporary Accommodation. Section 17.32 states that 'Living in Bed and Breakfast (B&B) accommodation can be particularly detrimental to the health and development of children'. The guidance further states that housing authorities should, therefore, use B&B (bed and breakfast) accommodation to discharge a duty to secure accommodation for applicants with family commitments only as a last resort and then only for a maximum of 6 weeks.

In Somerset data shows us that since January 2021 there is a count of 1,689 families/individuals having been placed in temporary accommodation (this is excluding the Somerset West and Taunton District Council area as this data was not available). Placement length varied significantly with the longest being 518 days, on average they lasted 39 days.

The most common type of placement was 'Privately managed Bed & Breakfast hotels (privately managed, meal/s provided, shared facilities)', a full break down can be seen in the figure below.

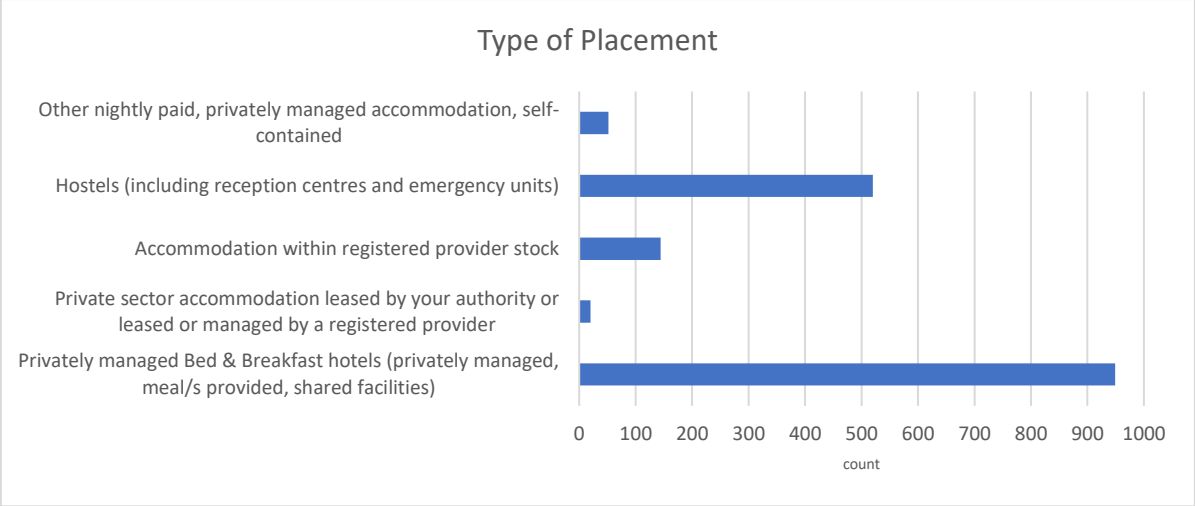

Figure 2 – Type of placement of those in temporary accommodation in Somerset (excluding west). Period: January 2021 – July 2023. (Directly with a private sector landlord, Accommodation within your own stock, and Other nightly paid, privately managed accommodation, shared facilities – are not shown due to low numbers).

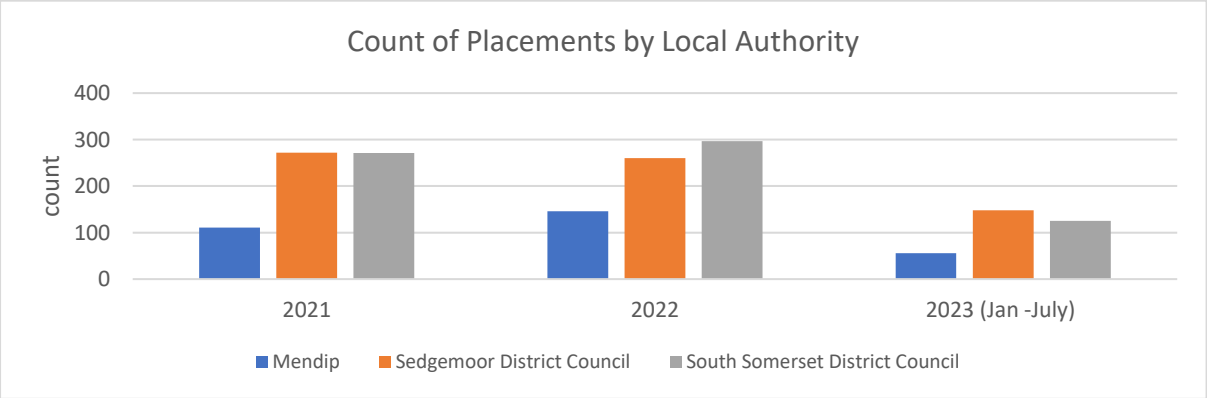

Figure 3 – Break down of individuals/families in temporary accommodation by area. For 2022 (last year with full data) the rate in Mendip was 1.26 per 1,000 population, Sedgemoor 2.07 per 1,000, South Somerset 1.72 per 1,000 (Based on these rates the average for Somerset is 1.68 per 1,000 population which, when applied to the population of SWAT would estimate a temporary placement count for that area of 264 (2022)).

In the time period of January 2021 – July 2023, there were a total of 520 children in the temporary accommodation placements across Somerset (excluding SWAT).

Adversity in childhood can impact on future homelessness. Adversity can include, but is not limited to, unstable childhood living arrangements and school absences. Children with frequent absences from school for example have been found to be 7.5 times more likely to report lived experience of homelessness. See section 4.2 below regarding ACES.

Homefinder Somerset

Homefinder Somerset is a 'choice based' lettings scheme allowing people to apply for social housing in Somerset. Registered households are placed in four bands – Gold, Silver and Bronze plus a separate emergency banding. The banding determines the urgency of their affordable housing need.

There were 11,628 households registered with Homefinder Somerset on 3 January 2023. This includes households with a live application and those who are being considered for a property

(with the status of 'Offered'). The proportion of households in Gold Band varied from 7% in Mendip to 9% in South Somerset. The proportion of households in the Silver Band ranged from 32% in Somerset West & Taunton to 54% in Mendip. Whilst the proportion of households in Bronze Band ranged from 39% in Mendip to 60% in Somerset West & Taunton.

In Somerset 52% of all household registered with Homefinder required a 1 bed home, with 28% needed a 2 bed.

Table 2 – Size of home needed; households registered as of 3 January 2023. Source: Homefinder Somerset

	1 Bed	
	No.	**%**
Mendip	1,129	51%
Sedgemoor	1,337	48%
Somerset West & Taunton	2,152	56%
South Somerset	1,413	50%
Total	**6,031**	**52%**

Between 1 October and 31 December, a total of 54,412 bids were placed on homes across Somerset. An average of 112 bids (increased from 106 in previous quarter) were placed for each of the 485 homes advertised between 1 October and 31 December 2022. The average number of bids for houses (168).

In Somerset West & Taunton there was an average of 205 bids for 2 bed houses compared to an average of 41 bids for 2 bed flats. The average number of bids for homes advertised during the quarter ranged from 105 bids in South Somerset (141 homes advertised) and Sedgemoor (113 homes advertised) to 136 in Mendip (74 homes advertised). There is a significant demand for housing with 42% of homes advertised during the last quarter receiving over 100 bids; the highest bids received was for a 1-bed in Bridgwater (379).

Some groups of the population are disproportionately impacted by homelessness (as will be expanded on in section '4 Key Risk Factors'). For example, based on the Somerset population data - both young people and women are overrepresented within Homefinder. Half of households registered with Homefinder Somerset have a main applicant aged between 18 and 39 years old; this is significantly greater than the proportion of the Somerset population aged between 18 and 39 (21% - 2021 Census). Two thirds (66%) of households registered with Homefinder Somerset have a woman identified as the main applicant, this is significantly different from the Somerset population where 51% are female (2021 Census)[10] .

More of a breakdown and national homelessness statistics can be found at: Homelessness statistics - GOV.UK (www.gov.uk)

2.4.2 Rough Sleeping

On a single night in September 2022 There were 57 individuals sleeping rough, (this is as part of scheduled national counting process), 45% of which had not had an offer of off-street accommodation.

However, across the whole month of September 2022 the data shows there were 89 people known to be sleeping rough in Somerset, 33% (29) of whom were new, 6% (5) who were under 25, and 9% (8) who had been discharged from prison. Somerset West and Taunton had the highest number of individuals rough sleeping on a single night (20), and South Somerset the lowest (7)[11].

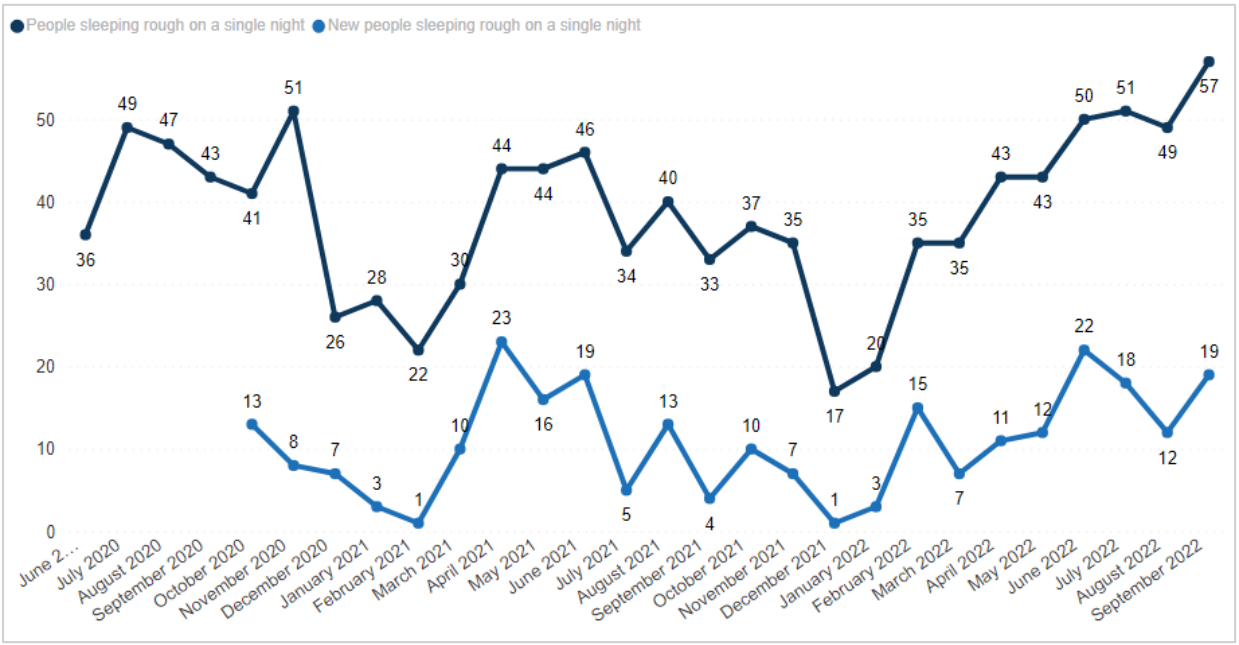

Figure 4 – Somerset People Sleeping rough on single night over time. Source: Department for Levelling up, housing, and communities (DLUHC).

DLUHC report that in 'off the street accomodation' there were 50 individuals, as of September 2022, 74% (37) of which had a 'HA 1996' homelessness application and a 'S189B' relief duty accepted; 96% (48) of these individuals were UK Nationals; 3 of these individuals had left off the street accomodation without move out arangements since the previous month.

DLUCH report 340 people had moved into medium and long-term accomodation since the pandemic, with 11 moving in the September 2022;3 of these individuals have been reconected, all with another local authority[12].

2.5 Covid-19 Impact

The 'Everyone In' initiative was launched on March 26th 2020, to provide emergency accommodation to those in need during the Coronavirus pandemic. The total number of people sleeping rough or at risk of sleeping rough who were provided emergency accommodation in England was 14,610, of which 4,450 were in London (May 2020)[13,14].

Since May 2020, The Department for Levelling Up, Housing and Communities has been collecting monthly management information from all local authorities in England about the support for people sleeping rough and those at risk of sleeping rough, alongside the annual rough sleeping snapshot statistics. On average, 95% of areas provide a response each month and for those areas that do not provide data, imputed figures based on previous latest management information has been used.

In response to the Covid emergency the Public Health team convened a Somerset Homelessness Cell, to coordinate the protect activity for rough sleepers. This incorporated all key partners including Public Health, Clinical Commissioning Group, district councils, probation, police, adults and children's social care, Turning Point and mental health services. The Homelessness Cell reported to the Community Resilience Cell. District Councils responded by establishing 157 bed spaces, utilising hotels, bed and breakfast accommodation, houses and a college campus. Housing management services and security were organised (all achieved in a little over two weeks).

Rough Sleepers – numbers supported and the important role of support services: With the onset of Covid, the number of rough sleepers rose considerably, despite the Government freeze on evictions. There may be many reasons for this; including people losing their jobs in a fragile employment setting (e.g., pubs, farm workers, chefs etc); vulnerable adults having to shield and requiring any friends/relatives who may be 'sofa surfing' to find alternative accommodation, and prison releases. The table below presents a quick snapshot of the number of rough sleepers that were supported across Somerset since the onset of Lockdown.

Table 3 – Number of rough sleepers that have been supported across Somerset since the onset of 'lockdown', by district. (All numbers under 5 have been supressed). Reported to the Somerset Health and Wellbeing Board.

Total	MDC	SDC	SWT	SSDC
Accommodated	20	27 (at peak)	68	53 (36 at peak)
Refusing to Engage	<5	6	9	<5
Evicted	<5	<5	<5	7
Moved on	10	9	10	22

The figure above and the detail found in the HWBB Rough Sleeping Report, are evidence to what can be achieved when all essential services are working together i.e., many people have been stabilised; have formed new friendships; are receiving the support they need; and many have moved on from emergency/temporary accommodation. Critical to this success is the nature of the accommodation provided i.e., self-contained non-hostel type facilities. Of note was the absence of any outbreaks of Covid-19 within the supported accommodation or hotel/halls of residence settings used during 'everyone-in'. Whilst there were individual cases at settings over the period there were no confirmed outbreaks (where two or more cases were active at the same time).

3 Key Outcomes for Homeless and Rough Sleeping Population

3.1 Health and Homelessness

The relationship between housing and health is complex, those living in poor housing or with no fixed abode frequently experience multiple disadvantage such as: unemployment, ill health, and social isolation.

Individuals who sleep rough experience some of the most severe health inequalities and report much poorer health than the general population. Many have co-occurring mental ill health and substance misuse needs, physical health needs, and will have experienced significant trauma in their lives.

Those who experience rough sleeping over a long period are, on average, more likely to die young than the general population.

They also face a higher likelihood of dying from injury, poisoning and suicide. It has been estimated that around 35% of people who die whilst sleeping rough die due to alcohol or drugs, compared to 2% in the general population.

In 2017, over half of all deaths of homeless people were due to 3 factors:

- accidents, including drug poisoning, accounted for 40%.
- suicides accounted for 13%.
- diseases of the liver accounted for 9%[15].

Homeless Health Needs Audit – The Unhealthy State of Homelessness[16]:

The (National) Homeless Health Needs Audit – the Unhealthy State of Homelessness, presents data from three groups: Wave 1 – (2012-2014), Wave 2 – (2015-2017), Wave 3 – (2018-2021). This presents aggregated data from 31 health needs audits undertaken from 2015-2021, representing 4,297 respondents – including data from Somerset. This aims to build on this existing knowledge, presenting up to date information on the health of people experiencing homelessness, and exploring what is known about whether the right services are available to adequately meet people's needs.

The majority of those included were sleeping in hostel or supported accommodation services. For complete demographics of those included in each wave see the full report at: Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com). This includes sections on life experiences associated with homelessness, and homeless health, this is referred to throughout the outcomes and risk factors section of this report.

3.2 Somerset NHS Foundation Trust analysis

Somerset NHS FT and its predecessor trusts reported almost 6,200 appointments with homeless patients in the 18-month period between January 2019 and September 2020. Attendance at appointments varied from service to service, but an analysis of the data at that time showed that 40% of appointments were DNA. The costs of such a high level of non-attendance are significant.

Missed appointments or a lack of preventative care through early intervention can result in individual patients from within the cohort requiring very long hospital stays and significant medical intervention which can lead to high financial costs to the system and significant personal impact for the individual. The NHS in Somerset reported a case study where in 2020 a homeless patient in their late 20s was admitted with an infection and needed their foot amputated. The cost of their care was more than £150,000 over an 11-week post operation

care period. Earlier intervention from an assertive outreach service, and the dual diagnosis team may have avoided both the amputation (as well as the impact that this will have on the rest of this patient's life) and the cost[17].

More recent data is displayed below, including homeless patients in NHS Somerset between January 2019 – May 2023.

Homeless individuals have been identified by searching for 'Homeless', 'home less', 'NFA', 'No fixed abode', as well as postcodes used to indicate homeless individuals. The information is broken down into A&E attendances, admissions to hospital, minor injury unit (MIU) attendances, community and Mental Health Admissions, and outpatient appointments.

3.2.1 A&E attendances

There was a total of 1573 attendances (Jan 2019 – May 23), from 586 individuals. The majority of these were at Musgrove Park Hospital (MPH) 1339, with 234 at Yeovil District Hospital (YDH).

Estimating how much these appointments may cost to the system is difficult as there are many unknown factors, however the estimated cost of an A&E attendance = £86-£418[18]. Based on this it is possible to estimate that the cost of these 1,573 A&E attendances (Jan 2019-Jun 2023) would be between £135,278 - £657,514.

An increasing trend can be seen for A&E attendances to both MPH and YDH, however MPH has consistently higher numbers. For this report the 2 hospitals have been aggregated as YDH has very low numbers.

A clear increase in attendances to A&E by homeless/NFA individuals can be seen from 2021 Q1. There was a total of 432 attendances recorded in 2022.

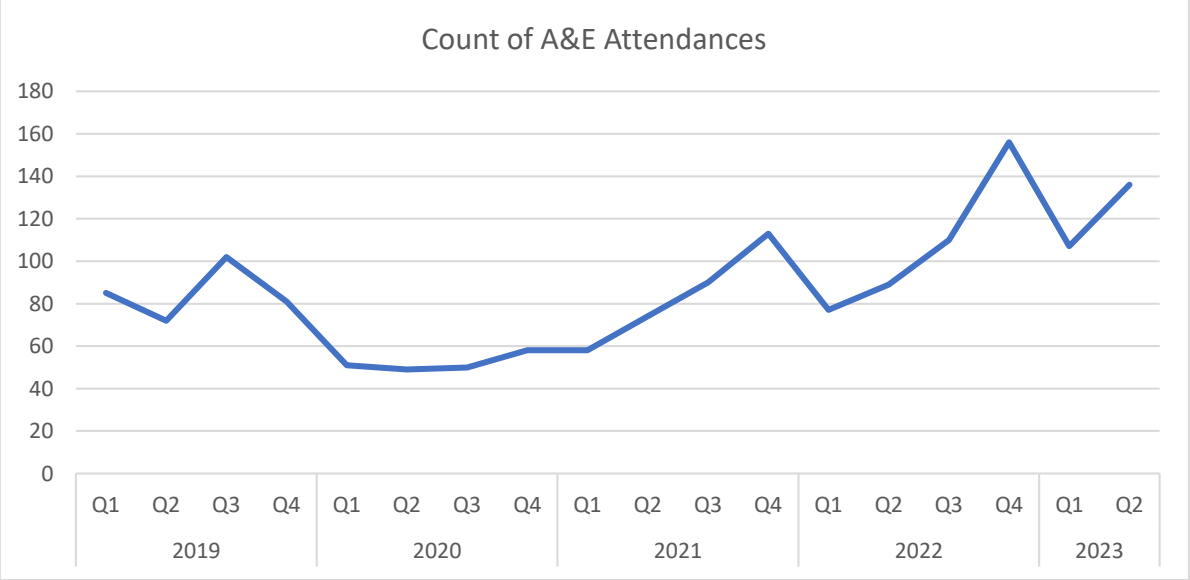

Figure 5 – Count of A&E attendances to MPH and YDH

The 10 most common diagnosis on A&E attendance are presented below for the time period January 2019 – May 2023. Null indicates that there was no diagnosis recorded, this may be due to individuals leaving A&E prior to assessment (this will be subject to further investigation).

Table 4 – Most common diagnosis on A&E attendance

Diagnosis	Total
Null	323
No abnormality detected	101
Alcohol (ethanol) intoxication	76
Other mental health disorder	71
Minor head injury (gcs>12)	58
Overdose	47
Social problem	32
Cellulitis	27
Recreational drug use	25
Anxiety	21

As other areas of analysis have highlighted the salient nature of mental health and substance misuse, the relevant diagnoses have been merged into these categories. For example, in the substance misuse category: alcohol, opioids, paracetamol overdose, alcohol withdrawal, drug-induced seizure etc. are merged and the mental health category: e.g., anxiety, depression, self-injurious behaviour, suicidal, etc. are merged. This is grouped by year and presented below – there is a decreasing trend in the number of A&E attendances for substance misuse but increasing for mental health.

No breakdown is presented by the diagnosis within these categories or by small periods due the sensitivity of this data, and this providing small numbers.

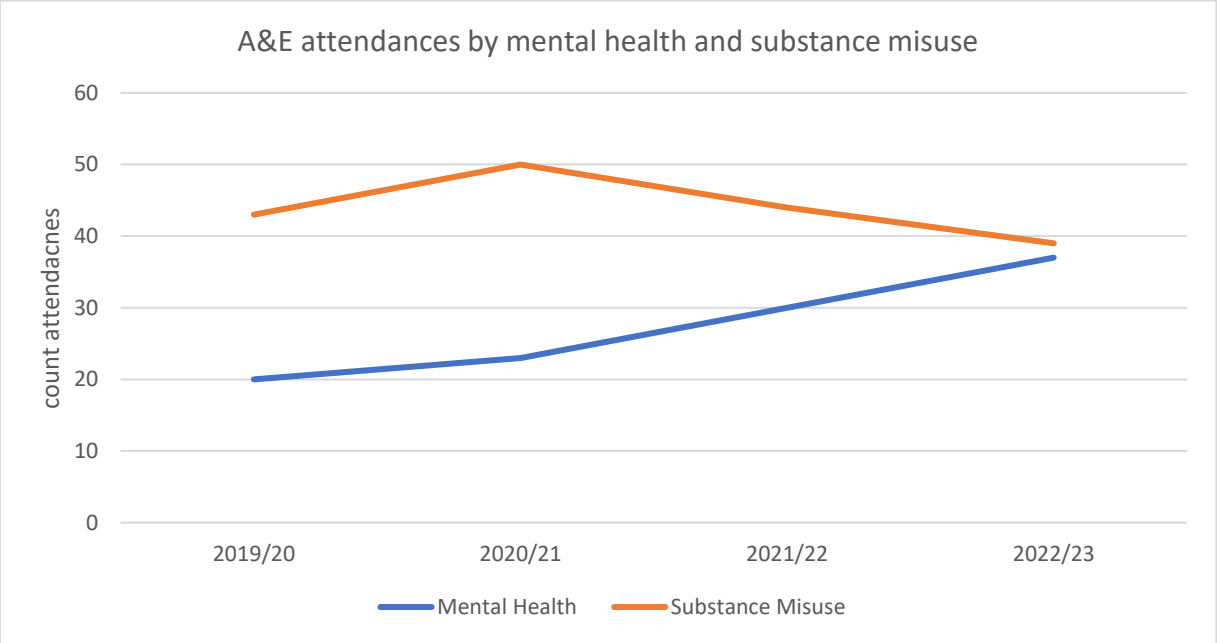

Figure 6 - A&E attendances by diagnosis of substance abuse or mental health

A&E attendances tend to be higher in the homeless and rough sleeping population (due to issues accessing other forms of care) than the general population.

In the general population A&E attendances are at a rate of 200.2–552.7 per 1,000 population – with Somerset being around average compared to other CCGs[19]. Looking at the data on the homeless population it can be estimated there is around 600 individuals in Somerset, with 432 A&E attendances in 2022 – there is an attendance rate of 720 per 1,000 population.

In Somerset the trend in general population A&E admissions has shown a 1.9% total growth in emergency admissions to A&E (2022-23)[20], the growth seen in the homeless population is larger than this (as above), however it is difficult to identify causal pathways for what this is due to. There are multiple factors at play including but not limited to changes in coding, improved case finding, and improved recording of housing status.

3.2.2 Hospital Admissions

MPH/YDH admissions by year – breakdown by month leads to too small data. There was a total of 328 admissions to MPH, and YDH over the period of January 2019 – May 2023; 284 at MPH, 44 at YDH. These 328 admissions were from 183 individuals.

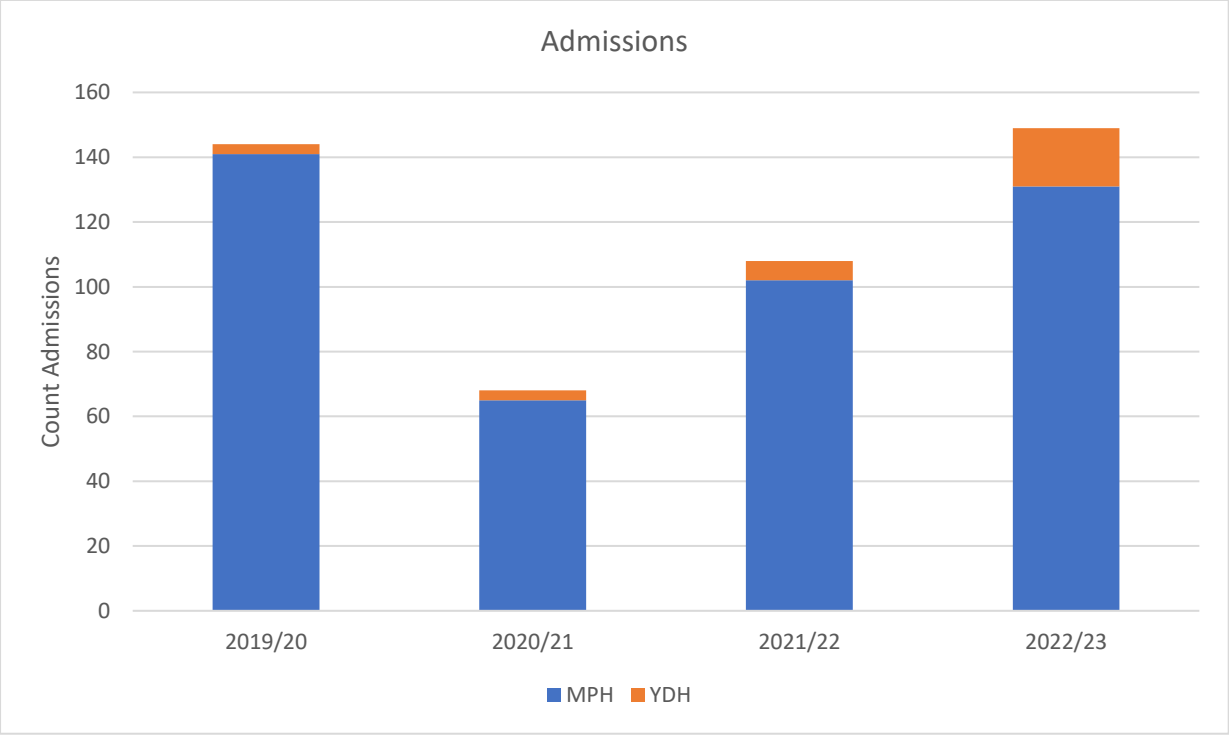

Figure 7 – Admissions by Hospital. Musgrove Park Hospital & Yeovil District Hospital

It is estimated that for Hospital inpatient admission - average cost per episode (elective and non-elective admissions)[21] is £2,941. Thus these 328 admissions could be estimated to have financial costs to the system of £964,648.

There may also be other long-term cost implications, as well as impacts to those individuals who have been admitted.

The total bed days for this cohort was 1380 days from these 328 admissions between January 2019 – May 2023. The average length of admissions fluctuates but is showing a generally decreasing trend. The average length of admission over this period was 4.2 days: 4.3 days in MPH, and 3.4 days in YDH. The average length of inpatient stay is presented below.

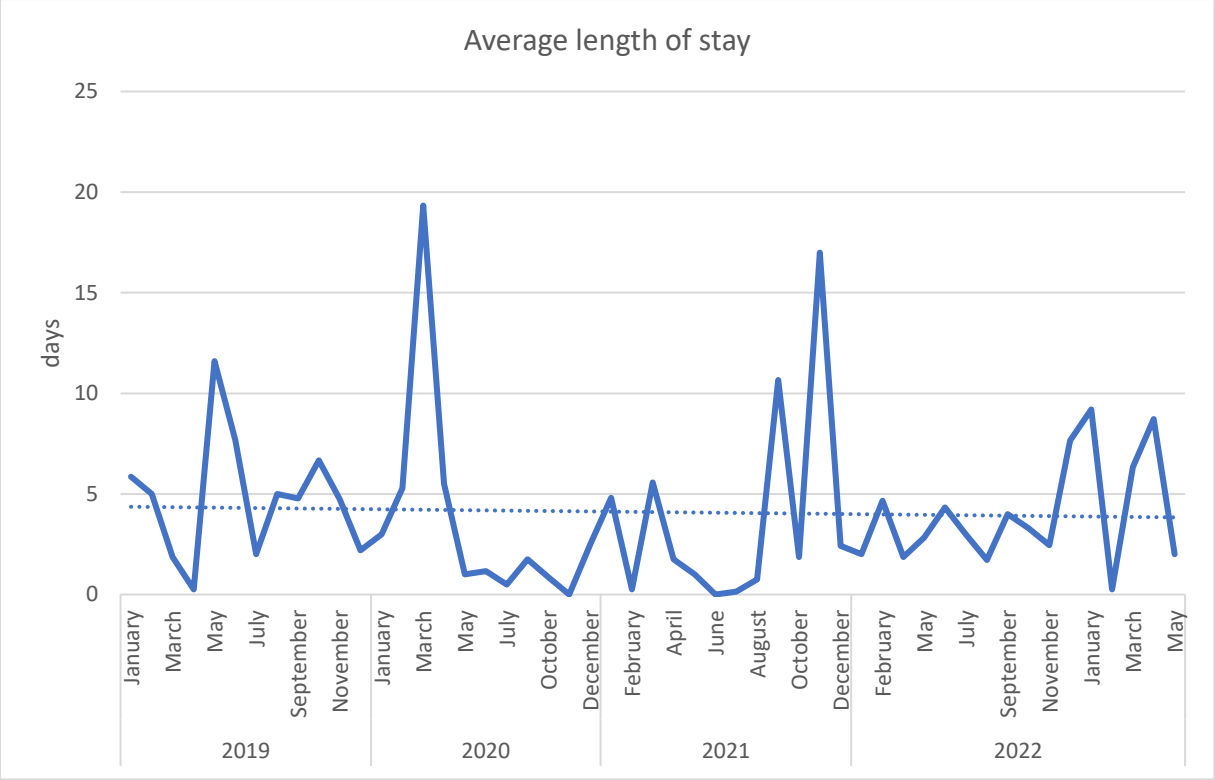

Figure 8 – Average length of inpatient stay

The 10 most common reasons for admission to either hospital are listed below:

Table 5 – Reasons for admission to hospital (January 2019 – May 2023)

Diagnosis	Count
Mental and behavioural disorders due to use of alcohol	30
Cellulitis of other parts of limb	15
Phlebitis and thrombophlebitis of other deep vessels of lower extremities	11
Syncope and collapse	10
Poisoning: 4-Aminophenol derivatives	9
Cutaneous abscess, furuncle and carbuncle of trunk	7
Null	7
Other and unspecified convulsions	6
Poisoning: heroin	6
Pneumonia, unspecified	5

The highest number of admissions for a single individual was 17 during this period. This same individual also had 30 attendances to A&E across this period. Based on the costs discussed above it can be estimated that this individual could have cost between £52,577 - £62,537 (£49,997 in admissions, and £2,580-£12,540 for A&E attendances).

Frequent attendance at A&E (even if the person self-discharges) is a red flag in itself in someone experiencing homelessness. Additionally, presentations tend to increase as the ability to cope decreases.

3.2.3 Minor Injury Units (MIU)

Attendance of MIU has seen a slightly decreasing trend since 2019.

Attendances to MIU are consistently higher in Bridgwater and West Mendip than other MIU Across Somerset. Bridgwater had a total of 75 attendances January 2019 – May 2023, and West Mendip 89.

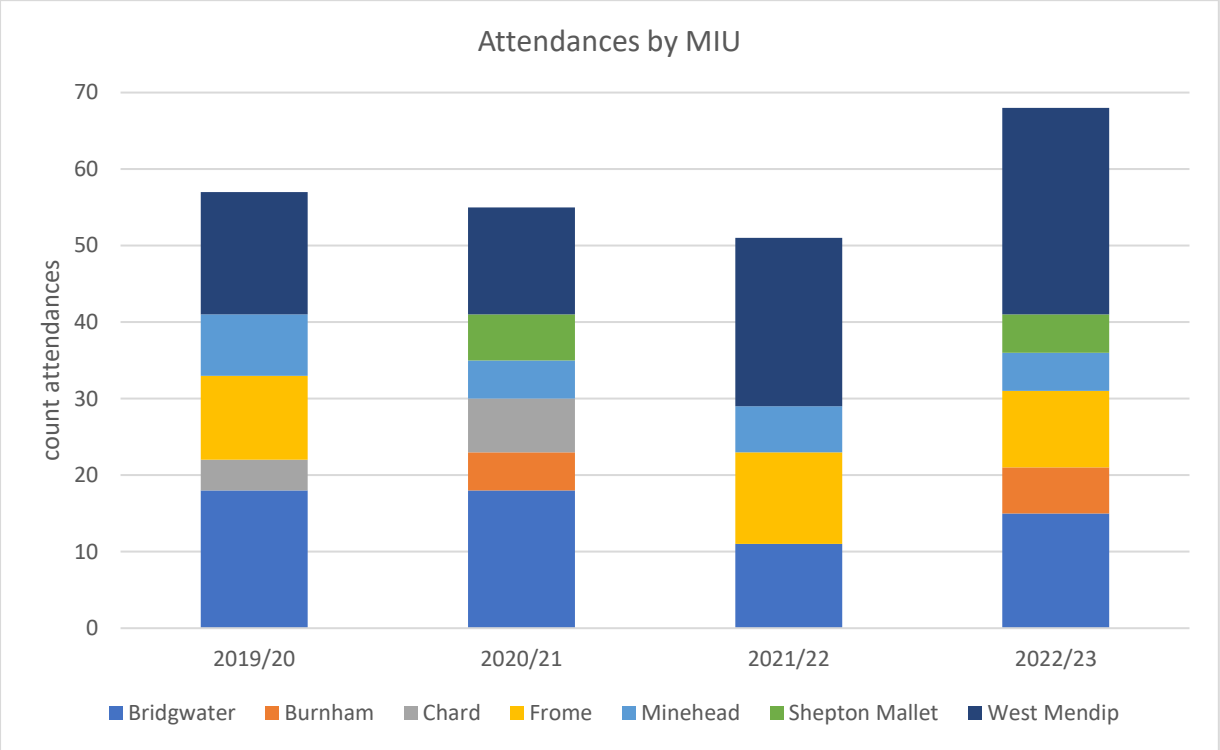

Figure 9 – MIU attendances by location (Any count smaller than 5 has been rounded to 0)

The most common presenting complaint to MIU in Somerset are outlined below:

1. Injury of shoulder/arm/elbow/wrist/hand - 32
2. Injury of hip / leg / knee / ankle / foot – 28
3. Wound: laceration – 30

3.2.4 Community and Mental Health Admissions for Homeless Patients

Despite the prevalence of mental health related conditions identified in the datasets referenced in this document the data in relation to community and mental health unit admissions suggests that the homeless cohort may be less likely to be admitted to hospital than the general population based on our understanding of A&E admissions detailed above – this may be an area for further exploration. There was a total of 22 appointments, for 9 individuals (Jan 2019 – May 23).

3.2.5 Outpatient Appointments

There was a total of 4,474 appointments during this period (January 2019 – May 2023), 1,716 first appointments, 2,510 follow ups (and 248 other).

Mental health is the most referred to speciality for outpatient appointments, with 3,302 of these appointments (74% of all the appointments in this period).

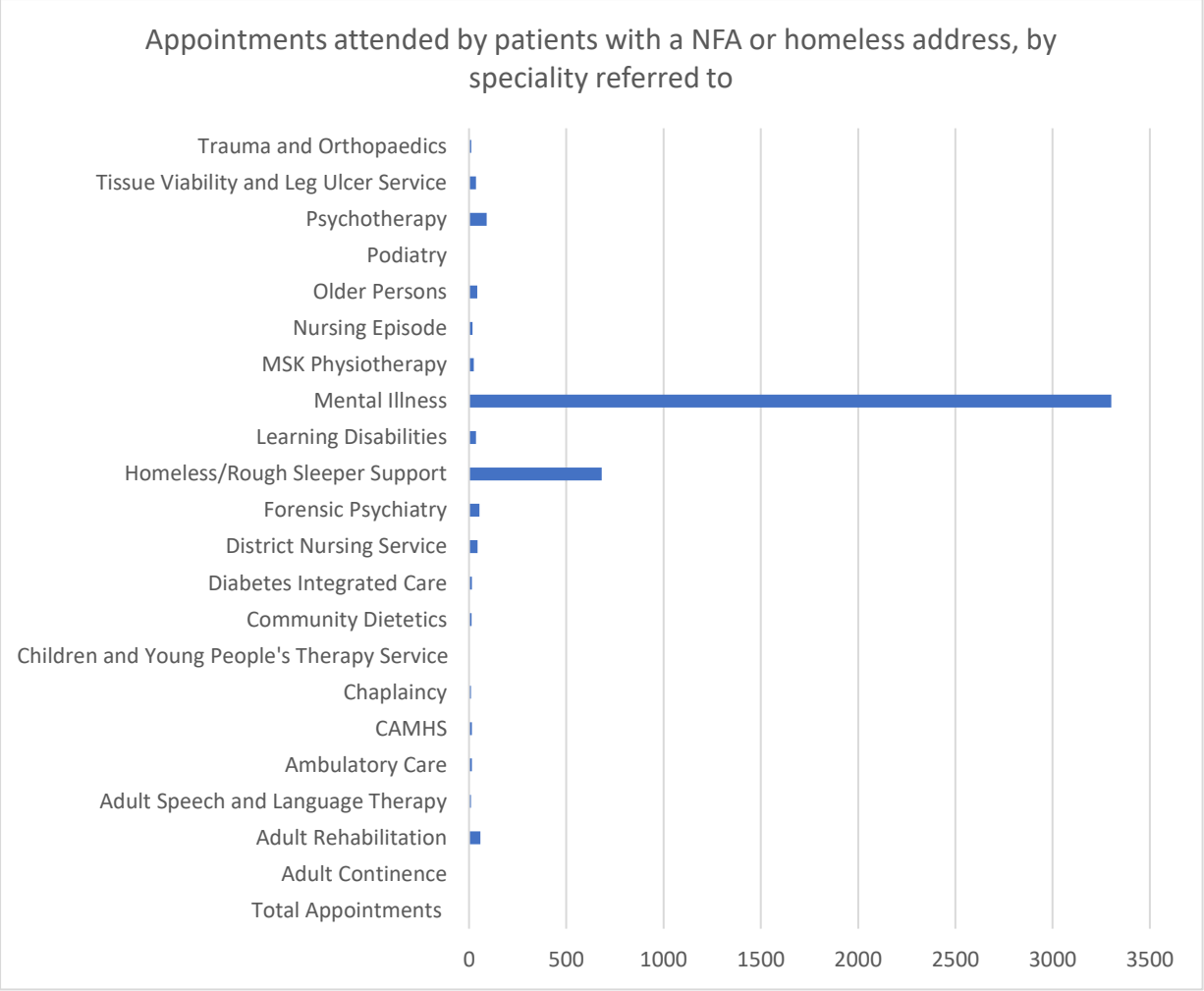

Figure 10 - Appointments attended by patients with a NFA or homeless address, by speciality referred to. (All count under 5 have been rounded to 0)

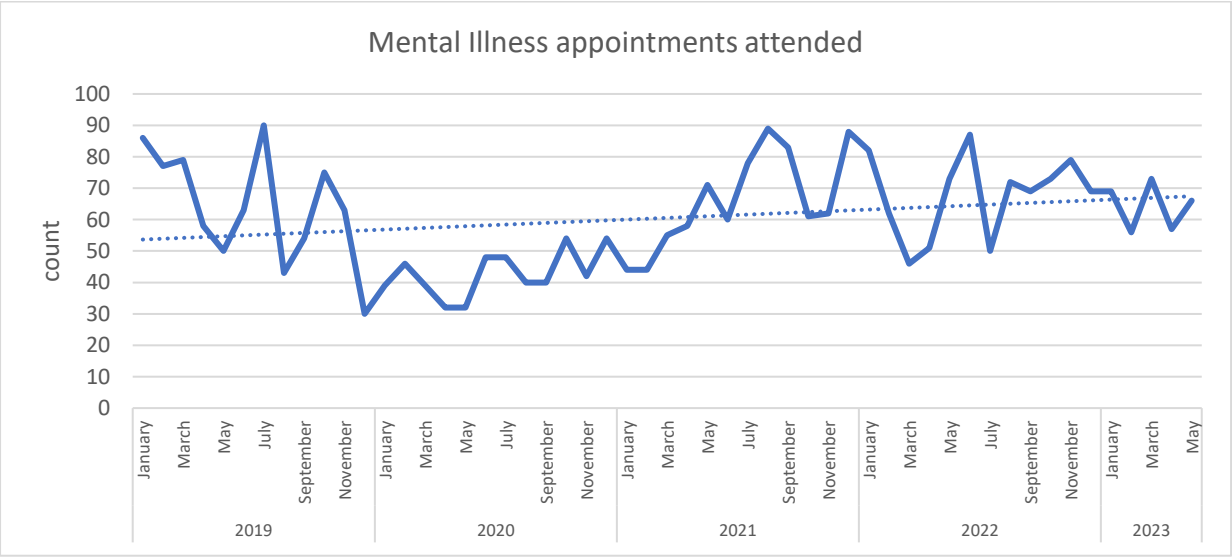

Figure 11 – Mental Illness Appointments Attended in Somerset FT

There is an increasing trend in the number of mental illness appointments, however the highest number in one month was seen in July 2019 (90). This increase in demand, and

worsening mental health is also seen across the general population – for more information see the 'Somerset - Mental Health Needs assessment' which can be found at: Mental Health Needs Assessment 2023.pdf (somersetintelligence.org.uk).

3.3 South West Ambulance Service Somerset Foundation Trust (SWASFT)

There was a total of 390 calls to SWASFT (South West Ambulance Somerset Foundation Trust) where the patient was identified as NFA, Homeless or No Fixed Abode, in the period of January 2019 – June 2023. The highest numbers of calls seen in an LSOA was 85, in both Taunton Priory, and Trull*; which reflects localities of previous or existing hostel accommodation. Most calls required 'See and Convey' (179/390).

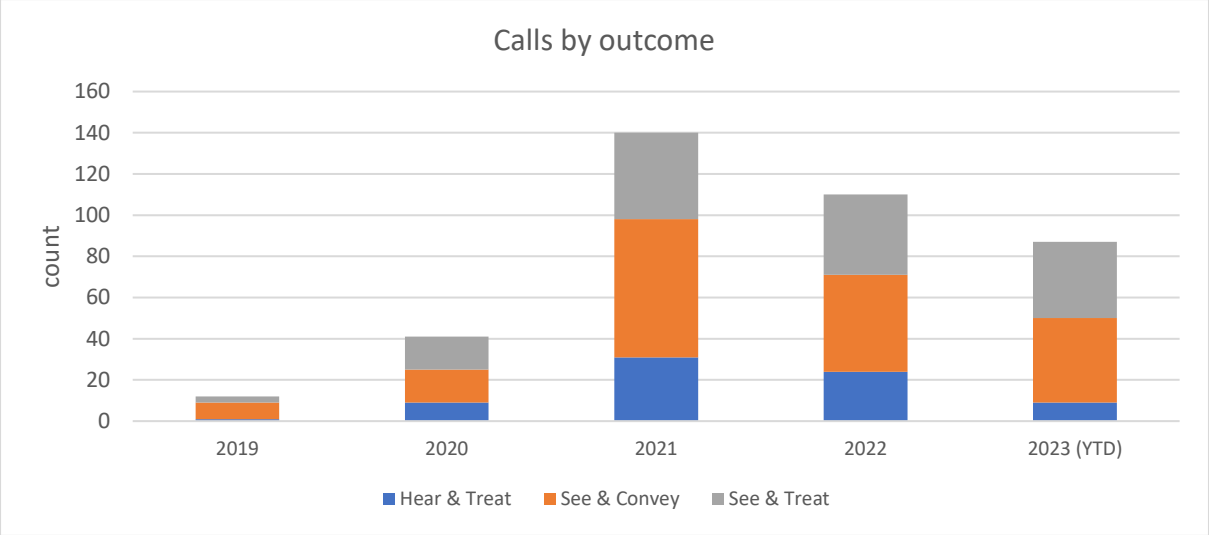

Figure 12 – SWASFT Calls for homeless/NFA (January 2019 – June 2023). Calls by outcome.

The most common 10 reasons for a call to SWASFT are outlined below:

Table 6 – SWASFT Calls for homeless/NFA (January 2019 – June 2023). Calls by call nature.

Call Nature	Count Incident
NHS 111	66
COVID-19	46
Convulsions/fitting	33
Psyc /Abnorm Behaviour/Suicide Att	32
Assault/ Sexual Assault	26
Overdose/Poisoning (Ingestion)	22
CSD CAT3 Escalation	19
Falls	17
Unconscious/Fainting (Near)	15
Chest Pain (Non-Traumatic)	12

* Patient housing status as homeless has been categorised by the following patient address criteria: County of incident was in Somerset and either the Address lines contain "no fixed abode", "nfa", "homeless", or either the postcode is like "ZZ99 3VZ", or is otherwise a specified location where the address lines contained "Lindley" with the post code of "TA1 3EZ", "Canonsgrove" and the postcode of "TA3 7HP", or "Pathways" and the postcode of "BA20 1NF". It's also important to note that patient address is not always recorded and complete, thus has a varying degree of quality.

3.4 Mental Health

Mental ill health is both a cause and a consequence of homelessness. Mental health problems can lead to homelessness – as individuals can become unable to cope with day-to-day life and sustain their tenancies. Homelessness in turn is an isolating, lonely experience which erodes confidence and self-esteem which can cause or exacerbate mental health conditions[22].

Actual, or fear of, homelessness can itself create stress which affects people's physical and mental wellbeing. People experiencing homelessness are at an increased risk of developing depression and substance misuse compared to the general population[23], with the mean prevalence of any current mental disorder being estimated at 76.2%[24]. These most commonly were alcohol use disorders (36.7%) drug use disorders (21.7%), schizophrenia spectrum disorders (12.4%), and major depression (12.6%).

Rates of suicide in the general population are higher in Somerset than nationally[25]. Additionally, a systematic review has presented that rates of suicide, and suicide ideation amongst homeless individuals are higher, than in the general population[26]. Research in 2009 found that Homeless people are over 9 times more likely to die by suicide than the general population.

The homeless population also has twice the levels of common mental health problems when compared to the general population and psychosis is 4-15 times more prevalent[27]. Additionally, a systematic review of the prevalence of mental health disorders suggests a prevalence of personality disorders as 25.4% in individuals experiencing homelessness[28]. For more information see section 3.10.

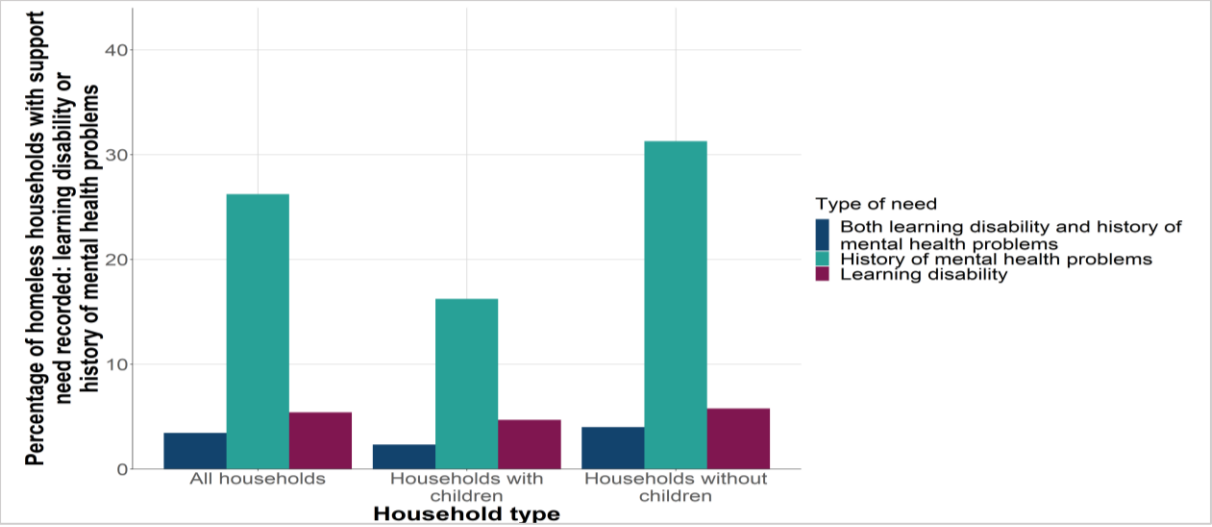

Figure 13 – Percentage of homeless households with a recorded support need: learning disability or history of mental health problem 2021/22. Office for Health Improvement and Disparities (2022) Spotlight indicator SP253

OHID data (2021/22) for all homeless households threatened with or experiencing homelessness (which includes individuals and families defined as those owed a statutory prevention or relief duty under the Homelessness Reduction Act 2017) showed that 26.2% reported a history of mental health problems, this was higher in households without children (31.3%) (see figure above)[29].

Crisis UK report that the most common assessed support need for homeless applicants owed prevention/relief duties (2020/21), is a history of mental ill-health, at 25%[30]. As discussed above prevalence of mental health conditions in the homeless population is higher compared

to the general population, poor mental health was the second most prevalent health problem identified in this population with 53.6% experiencing it[31]. There is, however, a range of estimates within these populations. Homeless Link Health Needs Audit (2016) estimated that 44% of the homeless population have a mental health diagnosis compared to 23% of the general population. It is also estimated that these figures increase to approximately 80% prevalence of a mental health condition in individuals who are sleeping rough[32].

The Homeless Health Needs Audit – the unhealthy state of homelessness[33] also reported that the number of people with a mental health diagnosis has increased substantially from 45% of respondents in wave 1 to 82% in wave 3. 81% of those with a mental health condition experience comorbidity, with 27% of respondents experiencing 2 such conditions. 72% of respondents reported experiencing depression, compared to a national rate of 10% pre-pandemic. 60% reported anxiety disorder or phobia, dual diagnosis with a drug or alcohol problem was reported by 25%. Additionally, 45% of respondents self-medicate with drugs or alcohol to help them cope with their mental health (Wave 3) and this has remained relatively stable across all waves.

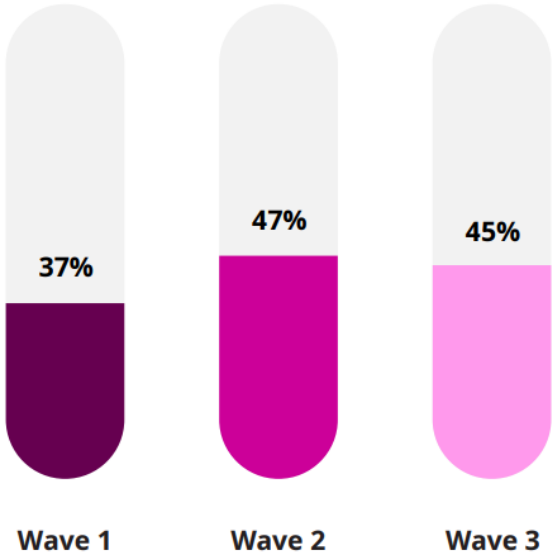

Figure 14 – Use of self-medication to manage mental health. Source: Homeless Health Needs Audit

Poor mental health is also a commonly reported outcome in the homeless population in Somerset. Extended interviews with individuals experiencing homelessness conducted in Somerset for 'Everyone In' (April 2020) revealed that, in addition to physical health concerns, 69% reported experiencing poor mental health. Additionally, research of 61 individuals living in general needs accommodation or with no fixed abode in Somerset reported that 77% had medium/high mental health support needs from the agency. Further to this 'Mental health issues (before or since becoming homeless)' was the most common factor identified in the Somerset homeless population, with 33/38 individuals identifying this (86.8%).

The Somerset Better Futures Analysis also showed that mental health was the most identified support need in the homeless population in Somerset.

The NHS health data above also shows mental illness to be a salient health need within the homeless and rough sleeper population.

NHS England as part of the Long-Term Plan has funded activity to deliver a specialist rough sleeping mental health service (2023). The NHS in Somerset have used this funding to further

expand the offer of the Homeless and Rough Sleeper Nursing Service through the recruitment of two Mental Health Nurses and two Mental Health Peer Support Workers to the team.

3.4.1 Executive Function

The ability to manage one's personal affairs and self-care is linked to executive function. Executive function is a set of 'higher-order cognitive processes that are essential for the cognitive control of human behaviours. They are the skills that help us 'get things done', the mental process that enables us to set goals, make plans and see them through. They are controlled by the frontal lobe of the brain[34]. When these processes are compromised, this is called executive dysfunction.

In cognitive science and neuropsychology, certain disorganisations of the mind or brain are widely recognised to be associated with executive dysfunction, and include acquired brain injury, dementia, delirium, learning disability, attention deficit and hyperactivity disorder (ADHD) and Autism – factors which impact a higher proportion of the homeless population. However, many other mental disorders can be associated with executive dysfunction including, schizophrenia, depression, anxiety, stress, general emotional and mental overwhelm.

The importance of considering executive functioning as part of mental capacity assessments, and how legal avenues such as the Mental Capacity Act 2005 and Care Act 2014 can provide an opportunity to 'open the door to people' and trigger more holistic support is becoming more widely understood as a result of recent research.

This is considered in terms of complex adults experiencing homelessness and 'executive dysfunction' by the following video Ellie Atkins - What you need to know, to end rough sleeping - YouTube and report The capacity to act ... opening the door for people with hidden disabilities and differences (kcl.ac.uk).

Adult Social Care in Somerset is currently undertaking a programme of work, which includes training, in relation to executive function across its operations workforce. It is already part of Mental Capacity Act /Deprivation of Liberty Safeguards training but is now going to have greater prominence. There will also be training at the annual Social Work Carnival of Practice in November 2023.

3.5 Physical Health

Homeless Health Needs Audit – National picture of Physical health in the homeless population[35]:

- 63% of respondents in wave 3 reported that they had a long-term illness, disability or infirmity. This compares to 22% within the general population.
- 78% (408) of respondents reported having a physical health condition.
- 80% of those with a physical health problem have more than one such condition, with 29% having between 5-10 diagnoses.
- Across all waves of data, joint aches/ problems with bones and muscles were the most commonly reported physical health condition – at 37% (194) in wave 3.
- Across all waves of data dental/teeth problems was the second most commonly reported physical health condition – at 36% (187) in wave 3.

Wellbeing:

- 76% (378) of respondents reported that they smoke cigarettes, cigars or a pipe. This compared to a national figure of 13.8%.
- Of those who smoke, 50% (156) would like to give up.

- 33% (153) of respondents typically eat one meal a day and 3% (16) of respondents do not eat any meals.
- 66% (301) of respondents ate one or fewer portions of fruit or veg per day. Just 4% (17) ate the recommended 5 or more.

As shown by the figure below there has been an increase in the proportion of respondents with a diagnosed physical health condition. These physical health conditions include: problems with feet, joint aches, dental, stomach problems/ulcers, skin/wound infection/problems, among others.

For more information on this report see: [Homeless Health Needs Audit Report.pdf (kxcdn.com)]

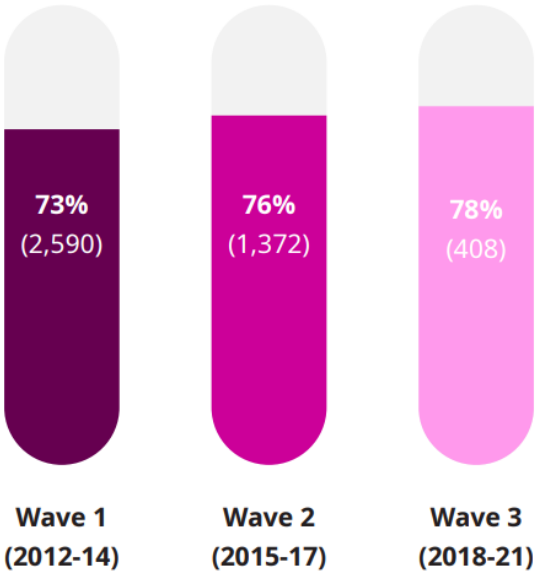

Figure 15 – proportion of respondents with a diagnosed physical health condition

3.5.1 Cardiovascular Disease

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels, this is grouped into 4 main categories: coronary heart disease, strokes, peripheral arterial disease, and aortic disease. CVD is a leading cause of death and disability in the UK, however, is often preventable by leading a healthy lifestyle.

Homeless individuals have approximately three times greater risk of CVD, and an increased CVD mortality compared to non-homeless individuals[36]. This review also suggests that future research should consider design and evaluation of tailored interventions.

As an ICS, Somerset is aspiring to meet the national 10-year cardiovascular disease ambitions by 2029. Local plans emphasise case finding and treatment optimisation for CVD risk factors whilst avoiding widening inequalities. NHS England's Innovation for Healthcare Inequalities Programme (InHIP) aims to address local healthcare inequalities experienced by deprived and other under-served populations. Somerset is currently running an InHIP programme entitled 'Cardiovascular case finding and treatment optimisation in primary care to improve uptake of innovative technologies with an emphasis on support for those homeless or rough sleeping'. This project will work with the staff and users to co-design strategies for CVD treatment optimisation in this vulnerable group. It will support GP practices to case find and use data to

address CVD need in vulnerable groups including those identified by HRSNS and also build on work to address deprivation and ethnicity inequalities.

Table 7 – Somerset CVD Dashboard, outcomes in the housed vs. homeless population – extract from November 2022. This is data from 15 GP practices across Somerset, which cover approximately 20% of the population[37]. Homeless no: 134. Housed no: 110,483.

	Homeless (% population)	95% CI	Housed (% population)	95% CI
Hypertension	13	7.5 - 18.5	16	15.8 - 16.2
Anticoagulants	8	3.6 - 12.4	6	5.97 - 6.03
Overweight (BMI 25-29)	41	32.9 - 49.1	36	35.7 - 36.3
Very overweight (BMI 30+)	20	13.4 - 26.6	17	16.8 - 17.2
Type 2 diabetes	8	3.6 - 12.4	6	5.97 - 6.03
Current smoker	64	60.4 - 75.6	13	12.8 - 13.2

As shown in the table above from a Somerset sample, being overweight or very overweight, is more common in the homeless population, as well as type 2 diabetes, however there is not a significant difference between the 2 populations. There is however a significant difference seen in smoking status, with a considerably higher percentage of the homeless population being current smokers.

Why people smoke is complex and can be linked to a range of factors including; peer pressure, social rewards (feelings of safety and security or community), risk-taking behaviour, self-medication, stress relief etc. Smokers who are addicted to tobacco report a range of positive sensations that come from smoking a cigarette. These range from reduced tension or appetite to a heightened sense of well-being. For some, smoking can be a way to self-medicate for illnesses that cause tension and pain. Patients suffering from some forms of mental illness, such as depression or anxiety disorders, may take up smoking because it can help mitigate some of their symptoms.

3.6 Self-neglect[38] e.g., wound management/access to food/sustaining accommodation

Self-neglect is an extreme lack of self-care. It often involves a failure to seek help or access services to meet health and social care needs and an inability or unwillingness to manage one's personal affairs and includes:

- lack of self-care to an extent that it threatens personal health and safety.
- neglecting to care for one's personal hygiene, health or surroundings.
- inability to avoid harm as a result of self-neglect.
- failure to seek help or access services to meet health and social care needs.
- inability or unwillingness to manage one's personal affairs.

The Care Act 2014 recognises self-neglect as a category of abuse and neglect, which means that people who self-neglect should be supported by safeguarding adults' teams, as well as receiving more general social care support. Many rough sleepers and people experiencing homelessness self-neglect to the point where this becomes a safeguarding issue.

In the Care and Health Improvement Programme (CHIP) *Analysis of Safeguarding Adult Reviews: April 2017 - March 2019* the most common type of abuse was self-neglect. Of the 231 reviews in the dataset 25 SARs were in relation to individuals who were either homeless or had experienced periods of homelessness. The report identified several common themes many of which were reproduced with respect to people experiencing homelessness, especially; missing or delayed assessments of mental health, mental capacity and risk/vulnerability, and discharges to no fixed abode[39].

NICE guidance for 'Integrated health and social care for people experiencing homelessness'[40] considers safeguarding within its recommendations:

- Designate a person to lead on safeguarding the welfare of people experiencing homelessness, including engagement and face-to-face practical safeguarding support.
- Where a social worker is embedded in the homelessness multidisciplinary team, local authorities should consider appointing them to lead on safeguarding enquiries about people experiencing homelessness.
- Local authorities should consider having a lead for people experiencing homelessness on the Safeguarding Adults Board.
- Safeguarding Adults Boards should ensure that specific reference is made to people experiencing homeless in their annual reports and strategic plan.
- Safeguarding Adults Boards should share recommendations and key learning related to homelessness from Safeguarding Adults Reviews with key stakeholders.
- Safeguarding Adults Boards should establish ways of analysing and interrogating data on safeguarding notifications about people experiencing homelessness so that they can check that local safeguarding arrangements offer the necessary protection.
- Commissioners and service providers should support health and social care staff to understand and apply laws relevant to people experiencing homelessness and who are in need of safeguarding. This should include ensuring that they can recognise signs of abuse and neglect (including self-neglect) and how to make a safeguarding referral.

3.6.1 Adult Social Care Data (Somerset)

Adult Social Care were approached to establish how many Care Act Assessments are carried out annually for adults identified as homeless or vulnerably housed and the assessment outcome. They were further asked whether it is possible to identify if self-neglect was identified as a care need for these adults.

This enquiry identified a gap in data recording as whilst anecdotally we have established from operational Social Workers and Housing colleagues that individual assessments have been completed in the past year it has proved difficult finding any useful data. That information is not being recorded in the case management system (Eclipse).

The data team are proactively looking at improving what information may be available and identifying what can be done to make it easier to report on this in the future. For example, having looked at the existing Classifications in Eclipse, they have established that there is nothing available which relates to homelessness. This issue will be raised with the Eclipse Change Board (Somerset Council).

The data team has also examined the address field, for those whose data is held in the system, as there is a 'homeless' option that can be selected where an address is recorded as 'location not known'. However, this field is not currently added to the data lake and searchable. This will now be amended to enable a report to be run in future which contains this data. However, as the secondary (homeless) option is not currently mandatory, there is a risk that there may

be no data recorded. This will need to be highlighted with operational staff to encourage better data recording in future.

3.7 Substance misuse

The relationship between substance use and experiences of homelessness are complex; homelessness is often associated with drug and alcohol misuse, and frequently occur simultaneously – however homelessness cannot be explained by substance misuse alone.

Substance misuse can be due to stressors associated with homelessness, conversely substance misuse and addiction can lead to homelessness. Individuals who are both homeless and have addictions face greater challenges in both finding housing, and overcoming substance abuse, due to stigma surrounding both substance misuse and homelessness[41].

The homelessness monitor: England 2022[42] found that homeless applicants with assessed support needs 8% associated with drug dependency, and 5% associated with alcohol dependency. Substance misuse may be an outcome of homelessness or a risk factor to becoming homeless, or both. 'Single Homeless Project' report that two thirds of people cite drug and alcohol use as a reason for first becoming homeless, with those who use drugs being seven times more likely to be homeless than the general population[43].

Drug and alcohol related anti-social behaviour is one of the reasons why individuals may be rejected/banned from social housing; with this being cited as an issue in 23% of individuals[44]. Nationally over one-sixth (17%) of adults entering substance misuse treatment in the year 2020-2021 stated they had a housing problem. This varied by substance group, from 1 in 10 (10%) in individuals starting treatment for solely alcohol problems, to approximately a third (30%) with problems with opiate use. Those with problems with new psychoactive substance (NPS), had the highest proportion of housing need (45%)[45].

National Homeless Health Audit – Drug and Alcohol Use:

- 54% of respondents had used drugs in the 12 months prior to taking part in a HHNA.
- Crack use has increased the most between waves 2 and 3. In wave 3 crack was the second most frequently reported drug, with 24% respondents using this; in wave 2 crack was the fourth most frequently reported drug, reported by 15% of respondents.
- 38% of respondents report that they have, or are recovering from, a drug problem.
- 20% of respondents regularly exceed the low-risk drinking guidelines, this compares to 24% of the general population.
- 29% of respondents have, or are in recovery from, an alcohol problem.

Substance misuse was also highlighted as a salient issue in the Somerset Homeless Audit (2021/22), in which 23/38 individuals had used drugs within the past 12 months, and 4/38 had alcohol consumption exceeding 14 units per week (NHS Guidance). Additionally, 26/38 individuals identified being a current smoker. Everyone invited 'In' during Covid in Somerset (April 2020) also found that 79% reported substance misuse.

The Covid period presented multiple challenges around accommodation settings and the use of substances. This was particularly so during a period of quarantine at one hostel setting where residents already encouraged to social distance agreed to be confined due to a case of Covid at the setting. A decision was made at the homelessness cell that the district council would support the residents and the accommodation provider by helping to meet the needs of the dependant drinkers living in the hostel recognising that abstinence or enforced detoxification would likely lead to staff and residents having to manage difficult behaviours.

Low strength alcohol was made available on request to residents each day. The setting reported no adverse incidents and anecdotally cite improved behaviours and less tension amongst the population. The residents adhered to the quarantine period.

During 'Everyone In' several settings reported improved support and a reduction in consumption amongst residents due to the increased in-reach support and having an accommodated population.

The management of Opioid Substitution Therapy (OST) which is defined as the administration of a prescribed (daily) dosage of opioid medicines to patients with opioid dependence problems also presented a need for pragmatic solutions to meet the needs of those moved into accommodation.

The approach to providing accommodation and support to those who misuse substances is fraught with difficulty and often leads to eviction at a time when the client is particularly vulnerable. This topic is considered by Scher in his 2023 report *Exploring low-barrier drug and housing interventions for people experiencing homelessness: Lessons from overseas and the UK*[46].

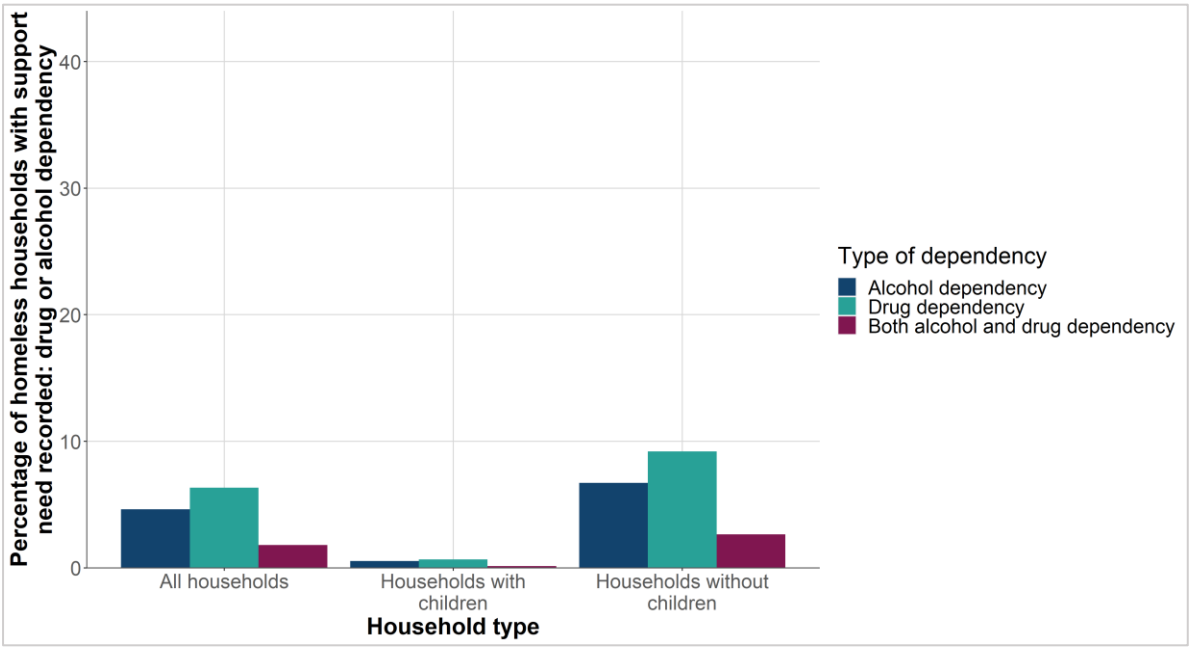

Figure 16 - Percentage of homeless households with a recorded support need indicating one or more individuals has a drug and/or alcohol dependency, 2021/2022[47]

Within all homeless households 1.8% had recorded drug and alcohol dependency, 4.6% had alcohol dependency, and 6.3% had drug dependency. This was higher in households without children, 2.7% reported both drug and alcohol dependency, 9.2% drug dependency, 6.7% alcohol dependency (see figure above).

3.7.1 Analysis from the Somerset Drug and Alcohol Service (SDAS)

The complete shared analysis can be found in appendix 1.

Between 2020/21-2022/23, 21% of the total adult clients entering treatment have been identified as either NFA or housing problem. The chart below shows housing status and substance in line with the four NDTMS drug categories.

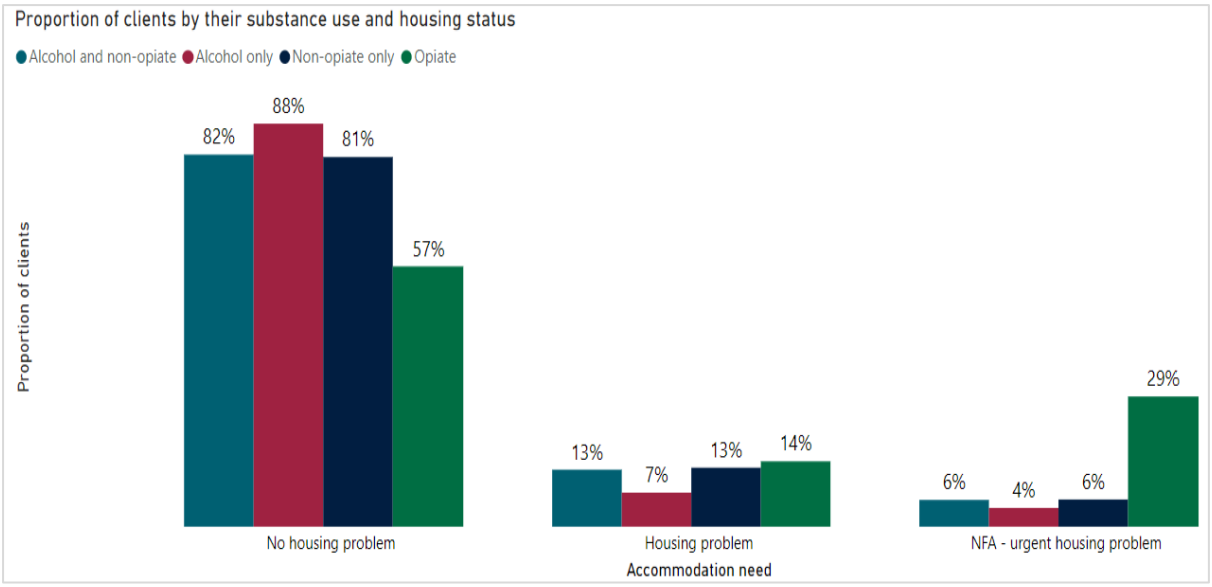

Figure 17 – SDAS - Proportion of clients by their substance use and housing status.

From the data of those accessing treatment we can see that proportionately alcohol only using adult clients are less likely to have a housing problem than other substance groups. Clients using opiates are highly likely to have housing problem or NFA. Analysing the past three financial years data, it indicates that 43% of opiate clients that came to structured tier 3 treatment had NFA/housing problem, while 19% alcohol and non-opiate clients had NFA or housing problem.

Of those who are identified as having Housing Problem or NFA and coming into the service for treatment for alcohol, drugs or both. The most common source of referrals of adult clients coming into the treatment are self-referral, followed by referrals from CARAT/prison. Other sources, as defined by NDTMS, and then Children Social Care, the national Probation Service, and general practitioners (GP). While we do have other referral sources, they make up a very small percentage, for example Domestic Abuse Service, NHS health checks etc.

Obstacles to treatment:

The service commissioned allows for self-referral and people can make that referral either by phone, online or direct through the SDAS outreach team. This sub team has two priorities within the homeless population: working especially with the hostels and supported housing and the acute hospitals to identify people who could benefit from treatment, and access to the service. In this latter situation SDAS in reach to the hospitals, especially Emergency Departments. There are also staff as part of the Young People's and Families Team that work Friday and Saturday nights – 7pm to 3am – in both Musgrove Park and Yeovil hospitals Emergency Departments to specifically target those under 25 years attending but will identify and engage with any age where drugs and/or alcohol is a factor in the attendance.

When an individual enters treatment alongside their assessment of need there is a risk assessment which seeks to understand a whole range of risk factors including risks linked to physical health and wellbeing as well as mental health. Of those who were identified as having Housing Problem or NFA and coming into the service for treatment, 49% of clients assessed as being low-risk physical health, while 39 % and 13% as medium and high-risk physical health respectively. Comparatively for the cohort with no housing problem, 52% of clients being assessed were identified as low-risk physical health while 39% and 8% as medium and high-risk physical health respectively.

Of those who have housing or NFA problem, the percentage who leave treatment as treatment complete is 33.6%; while the treatment complete figure for individuals that have no housing issue is 54%. On the other hand, we see high proportion of adult clients with NFA, or housing problem are more likely to have an incomplete treatment journey. For each £1 spent on treatment the system will save £4 due to reduced demands on health, prison, law enforcement and emergency services.

3.7.1.1 Substance Misuse and Mental Health

68.8% of those clients who have been identified with housing problem or NFA have a mental health need.

Table 8 – SDAS - Mental health needs of those with a housing problem/NFA compared to individuals with no housing problem.

Client has a Mental Health Need	NFA or Housing Problem	No Housing Problem
No	31.15%	36.12%
Yes	68.85%	63.88%

64.7% of clients within housing problem or NFA client group who have identified as having mental health needs are receiving treatment for their mental health.

3.7.2 Brain Injury and Alcohol related brain damage (ARBD)

A systematic review previously found that 53.1% of homeless and marginally housed individuals had suffered a traumatic brain injury within their lifetime, with 22.5% suffering a moderate or severe brain injury[48]. Alcohol-related brain damage is an umbrella term, encompassing several conditions all characterised by cognitive impairment. This can be due to a variety of causes, such as the impact of alcohol on other organs, alcohol toxicity, history of head injury. Cognitive deficits are also common in the homeless population, often secondary to an acquired brain injury (related to physical trauma and/or alcohol related damage).

Data provided by NHS Somerset, shows assault as well as head injury as frequent reasons for attendance. The HRSNS reported case finding amongst their patient cohort. In one case a patient was diagnosed with both ARBD and Dementia – despite these conditions likely to have been present for some time, and the client repeatedly coming to the notice of the criminal justice system, neither health need had not been identified previously.

3.8 Tri-morbidity

People experiencing homelessness along with other groups such as people in the prison system and sex workers, are commonly described as suffering from 'tri-morbidity'49,50. Tri-morbidity can be difficult to manage, due to its complexity.

‘Tri-morbidity’ is the intersection of physical health, mental health and addictions conditions.

For example:

- In the results of a large survey of people experiencing homelessness in 2022, 82% of respondents reported some form of mental health issue[51]
- 6 in 10 people sleeping rough in London had a drug or alcohol problem in 2018[52]
- As well as a higher prevalence of chronic diseases people experiencing homelessness experience higher rates of infectious diseases e.g., Hepatitis C, Tuberculosis and HIV[53]

The ’Shooting Up: infections among people who inject drugs in the UK[54]’ report published by UKHSA and updated in March 2023, states that socially excluded communities, such as People Who Inject Drugs (PWID) experiencing homelessness and those not currently in

contact with drug and alcohol services, should receive additional targeted support to enable them to access harm reduction services, regular BBV testing and care.

Prevention, detection and treatment of infections, related to injecting drug use, remain issues of public health concern in the UK. Hepatitis C virus (HCV) remains the most common BBV infection among PWID in the UK. Whilst there is evidence for a continuing decline in the prevalence of chronic HCV infection in this population, which is largely due to improved testing and access to direct-acting antiviral (DAA) treatment the prevention of new and re-infections remains a challenge. In addition, there has been an increase nationally in the proportion of people unaware of their HIV status.

A concerted effort is required to improve testing, and to ensure that everyone living with HIV is aware of their status and can access treatment. Finally, there is increasing concern with regards to invasive group A streptococcal (iGAS) disease and other causes of sepsis amongst those who are homeless or at risk of homelessness.

Currently there is incomplete data for the Somerset population in relation to these health issues due to the relatively low numbers and various reporting and treatment approaches at play across the county. However, significant progress has been made in improving access to testing for Blood Borne Viruses, among people who inject drugs and within sexual health services. Additionally, we have shifted the focus of infection, prevention and control strategies in Somerset towards a more preventative approach. The IPC team is working with the drug and alcohol service to ensure messages reach those users, the drug and alcohol service also provide a needle exchange service to ensure as part of a Harm Reduction approach, clean needles are used.

There remains a need to better coordinate our reporting of BBV testing results. For HIV the system works well but for Hepatitis's, these are notifiable organism and so reports go from laboratories through to UKHSA, this needs to be fed back locally to ensure that the data informs targeted activity within this cohort and those who support them.

This intersection of conditions often makes the treatment of each element more challenging, particularly in a siloed health care system[55]. Tri-morbidity and complexity leads to people experiencing homelessness often aging earlier than the general population, as well as dying earlier. For example, Rogans-Watson et al[56] found that 33 people living in a homeless hostel with a mean age of 55.7 years had an average frailty age comparable to 89-year-olds in the general population. Additionally, the average number of long-term conditions experienced by the participants of this study was 7.2.

It is recommended that substance use, mental health and homelessness services adopt evidence-based approaches to tackling drug misuse such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments[57]. As well as ensuring understanding of the impact of stigma and treating individuals with respect and involving individuals with experience of homelessness and substance use in design and delivery of services.

The NHS Long Term Plan (LTP) committed to investing up to £30 million over 5 years to meet the health needs of rough sleepers to ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services. In 2022 the South West region, having considered the annual rough sleeping count (October 2021), other local intelligence on numbers, complexity of systems and other funding streams already received, agreed to prioritise

Somerset and distributed funding to establish rough sleeping mental health services in Somerset. This funding has been deployed to the HRSNS and resulted in the addition of two Mental Health Nurses and two Mental Health Peer Support workers being recruited to the team.

3.8.1 Somerset Better Futures Analysis[58]

The Better Futures work helps to inform what is known about tri-morbidity. This analysis includes 358 individuals from across Somerset, 26.8% female, 70.1% male, and 3.1% not known. The majority (75.7%) of individuals were in the 25-54 age group. Most referrals came from 'housing options team' 45.0%, followed by 'other' (which encompasses SSDC, Rethink Mental health, probation, pathways transfer, among others), at 27.7%.

Health and care needs were identified amongst 210 individuals in this analysis. For both males and females, mental health was the most common health and care need identified and was the most common factor identified in all age groups. 81.2% of males, and 92.4% of females identified mental health as a health and care need, the full break down is shown in the figure below.

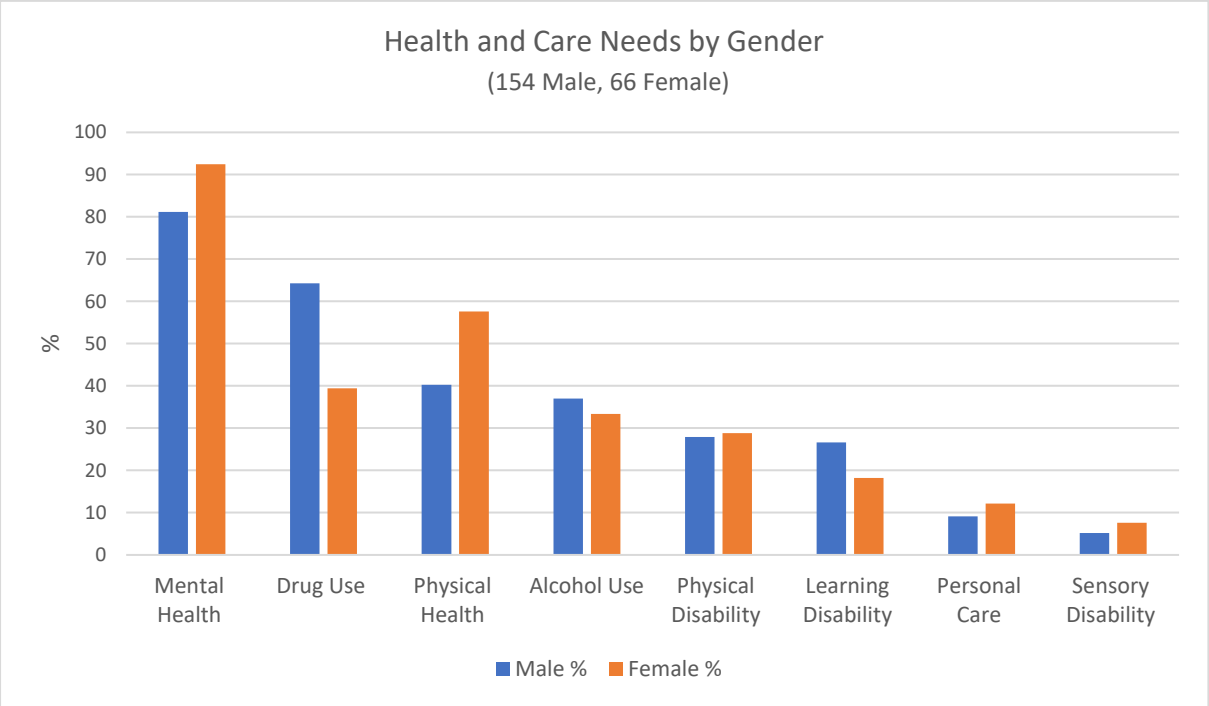

Figure 18 – Somerset Better Future Analysis, Health and Care Needs – by gender.

The figure below shows that mental health support needs are the most common, this (as above) is the seen in both males and females; additionally mental health has the highest severity needs for both males and females. In females, domestic abuse is the second most common support need, and in males this is drug use (full breakdown by gender can be found in the appendices).

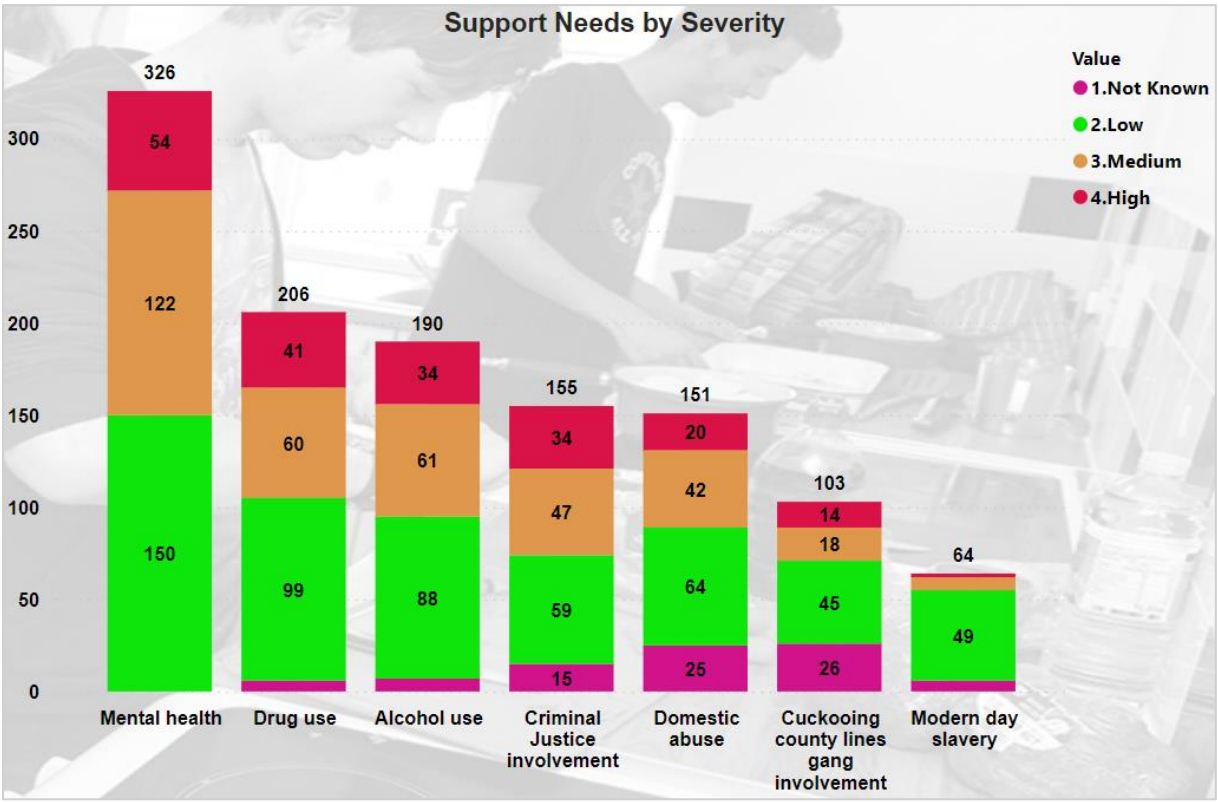

Figure 19 – Somerset Better Future Analysis - Support needs by severity

Combined support needs broken down by gender can be seen in the figure below:

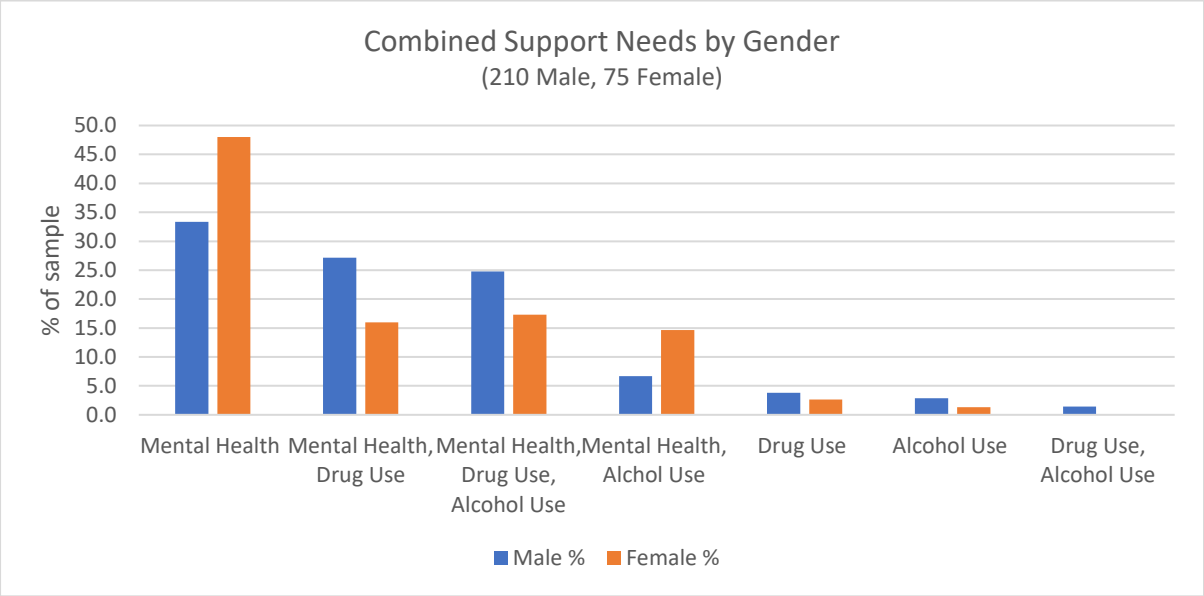

Figure 20 – Somerset Better Future Analysis – Combined support needs by gender

3.9 Access to Services

"They are not hard to reach clients. We have just got hard to reach services"[59].

NICE Guidance[60] recognises the obstacles created for this cohort by the existing universal approach to health and social care provision and that people experiencing homelessness may find services difficult to engage with or may find it difficult to look after themselves because of their circumstances.

The guidance recommends taking health and social care services to people experiencing homelessness by providing multidisciplinary outreach care in non-traditional settings, such as on the street, hostels or day centres.

This includes offering outreach services that include support for people who:

- have primary healthcare needs.
- have drug and alcohol treatment needs.
- have mental healthcare needs.
- fear engaging with services, for example, because of previous negative experiences from providers, discomfort using male-dominated services or concerns about eligibility including immigration status.
- may lack mental capacity or need support to recognise their care needs and engage with providers.

It also encourages using outreach to identify health problems earlier, promote health and support engagement with care, for example by:

- supporting access to national screening programmes
- assessing people for long-term conditions, infectious diseases and mental health needs
- providing preventive health opportunities, such as vaccination, drug and alcohol treatment services, harm minimisation, smoking cessation and nutrition advice.

Where an existing but previously unmet need is met through outreach provision it seems reasonable to anticipate seeing an increase in recorded health demand through; appointments, screening, diagnosis and referral. It is also reasonable that as a consequence of an offer with increased access there should be a real potential to see a reduction in demand elsewhere on acute or emergency services/settings for example as client groups habits change and trust and confidence grows in the outreach provision where a prevention approach to care, diagnosis and treatment takes place in accessible settings. Whether this is indeed the case will need to be observed over time, as the population health needs are increasingly met, and individual patient demand is stabilised.

3.9.1 Preventative care and Screening

Individuals who are homeless or rough sleeping experience higher rates of vaccine preventable disease then the general population – however the delivery of vaccinations to this population can be complex. Vaccination strategies suitable for this cohort include vaccination clinics, using convenient locations, accelerated vaccination schedules, and training for staff in working with homeless population among others[61].

For COVID-19, the JCVI advised that individuals experiencing homelessness (incl. those rough sleeping) should be prioritised for vaccination - many individuals who are homeless or sleeping rough are likely to have underlying health conditions which would place them in priority group 6, these are likely to be under-diagnosed or not properly reflected in GP records[62]. In the year from January 2021 bespoke homeless vaccination sessions at accommodation and community settings in Somerset offered the Covid-19 vaccine to 360 homeless or vulnerably housed adults with 236 (65% of the population) taking up the offer. By February 2022 over 550 doses had been delivered (V1/V2/Booster).

Homelessness is a significant risk factor for Blood Borne Virus (BBV) infection such as Hepatitis and HIV. The national Homeless Health Audit reported that in wave 3 only 6% of the respondents were fully vaccinated against Hepatitis B[63].

The chronic prevalence of Hepatitis C Virus (HCV) amongst the homeless cohort has been estimated at 29%[64]. Homeless people diagnosed with HCV infection are also less likely to complete treatment. The reasons for this are complex, but involve mistrust of medical services, inflexibility of secondary care pathways and geographic mobility.

Recognising that homeless people diagnosed with HCV infection are less likely to complete treatment Public Health, working with NHS and VCSFE partners, engaged in pilot activity which was completed during 'Everyone In'. Across 8 settings, 103 people were screened (75.2% of total population), Thirty-one (33.7%) screened positive for HCV antibodies; of these, 14 (15.2%) were HCV RNA positive, indicating chronic infection. As a result of the learning from that pilot Bloodborne Virus Screening for the homeless community in Somerset is now an embedded approach.

The HRSNS report completing a minimum of 86 Dry Blood Spot Tests over the 15 months since March 2022. This figure is likely to be higher. Both outreach GPs report BBV case finding including HCV and HIV.

SDAS have implemented a BBV improvement plan aiming to achieve better practice in delivering testing, treatment, and vaccination, and to improve the quality of data recording, with the ambition of all clients being offered Hepatitis B vaccinations where appropriate. Wider workforce training has also taken place to increase case finding (e.g., HIV identified within the cohort and targeted testing and treatment commenced).

Access and use of screening can be lower in the homeless population. An example being women experiencing homelessness, are less likely than the general population to access services such as cervical and breast screenings, with 37% of those surveyed (in the national Homeless Health Needs Audit) having had a breast screening, compared to 61.8% of general population[65].

Homeless Health practitioners are now deploying Fibroscan devices via outreach. Fibroscan allows non-invasive screening of liver health using ultrasound technology and is commonly used in patients who have been diagnosed with or are being monitored for hepatitis C (HCV), chronic hepatitis due to hepatitis B (HBV), a combination of hepatitis C and HIV, alcoholic liver disease, hepatic steatosis (fatty liver) non-alcoholic, chronic cholestatic diseases, liver cirrhosis, Liver Screening and Cardiovascular Disease.

Somerset Public Health working in partnership with NHS colleagues are currently participating in the *Innovation for Healthcare Inequalities Programme* (InHIP) - the Somerset project is primarily focussed on novel therapies for high cholesterol but as part of a holistic approach to cardiovascular disease (CVD) prevention will also incorporate care in other areas relating to CVD prevention. The main inequality focus being on the population experiencing homelessness. The homeless population have a higher predicted risk of poorer CVD outcomes. Four key areas are: Dyslipidaemia (high cholesterol), Diabetes, Hypertension, Smoking.

It is worth noting that in addition to their screening and vaccination activity, SDAS have also been proactive around harm reduction with the introduction, training and provision of Naloxone in Somerset. Naloxone is a medication used to reverse the effects of an opioids overdose. Many staff working in homeless services and accommodation settings have been trained and supplied with Naloxone. SDAS have also established a programme with Somerset Police where their staff will be trained to use and carry Nyxoid – nasal naloxone.

3.9.2 Access to Medical Care

Access to services such as GP's and hospital appointments, can often be a complex issue for the homeless population due to issues with; self-management and executive functioning, poor practice within surgeries, access to telephones and transport and stigma for example. This has been further exacerbated by the shift to digital and online services which provide additional challenges regarding access to IT and services.

The current Homeless and Rough Sleeper Nursing Service and Inclusion Health Outreach GP approach in Somerset provides an outreach approach to accessing medical care and supports clients in facilitating access to secondary services across the county (see below).

GP registration is supported by both the Outreach GP and Nursing Service – both having developed links into numerous surgeries across the county. There is currently no data collection in relation to the number of GP registrations facilitated by the HRSNS or outreach GPs. Both current Outreach GPs provide formal Inclusion Health training to junior doctors.

3.9.2.1 Homeless and Rough Sleeper Nursing Service – Somerset

NHS in Somerset, working in partnership with colleagues in Public Health, VCFSE sector and local government, have successfully developed an approach to meeting the health needs of some of the most vulnerable adults in our communities through the introduction of the countywide Homeless and Rough Sleeper Nursing Service which delivers targeted outreach, and care coordination of the holistic health needs for individuals within this group.

The team currently consists of 1x Clinical Lead, 4x Band 7 Physical Nurses, 4x Health Link workers, 2x Mental Health Nurses and 2x Mental Health peer support workers plus one administrator. An experienced Nurse and Health Link worker each cover 1 of the 4 areas of Somerset, East (Mendip), North (Sedgemoor), South (South Somerset) and West (Somerset West & Taunton).

The team meet the needs of a diverse client group: people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

The threshold free outreach approach provides health care in a range of accessible non-traditional settings; in the field, on the street, at VCFSE community drop-ins and accommodation settings – headlines include:

- Bespoke Covid-19 sessions offered the vaccine to 360 homeless or vulnerably housed adults with 65% taking up the offer. By February 2022 over 550 doses had been delivered (V1/V2/Booster).
- Hepatitis/HIV. Pilot activity completed during ‘Everyone In’ found that of 103 people screened 33.7% were positive for HCV antibodies; 15.2% of whom were HCV RNA positive, indicating chronic infection. Bloodborne Virus Screening for the homeless community is now routine.
- Community run clinical settings in Taunton and Yeovil – provide GP and Homeless Nursing Team, Sexual Health, Drugs and Alcohol, Vaccination clinics – seeing hundreds of unique visitors each month.
- Bespoke, health (Nursing Team, Dual Diagnosis, Vaccination, Sexual Health, Drugs & Alcohol, Oral Health) sessions at nine separate accommodation settings and community venues.
- Regular vulnerable migrant worker sessions in Sedgemoor

- Focussed Van Dweller and Traveller Community support in Mendip.

As of June 2023, the nursing team had seen 871 individual clients since being established in March 2021, completed 4469 appointments, with an average 300 client contacts per month.

Referrals to the team have increased by 296% from 21/22.

From April 2022-June 2023 there was a total of 831 referrals with 604 assessments being completed. Overall, 24% of all clients have subsequently been registered with a GP.

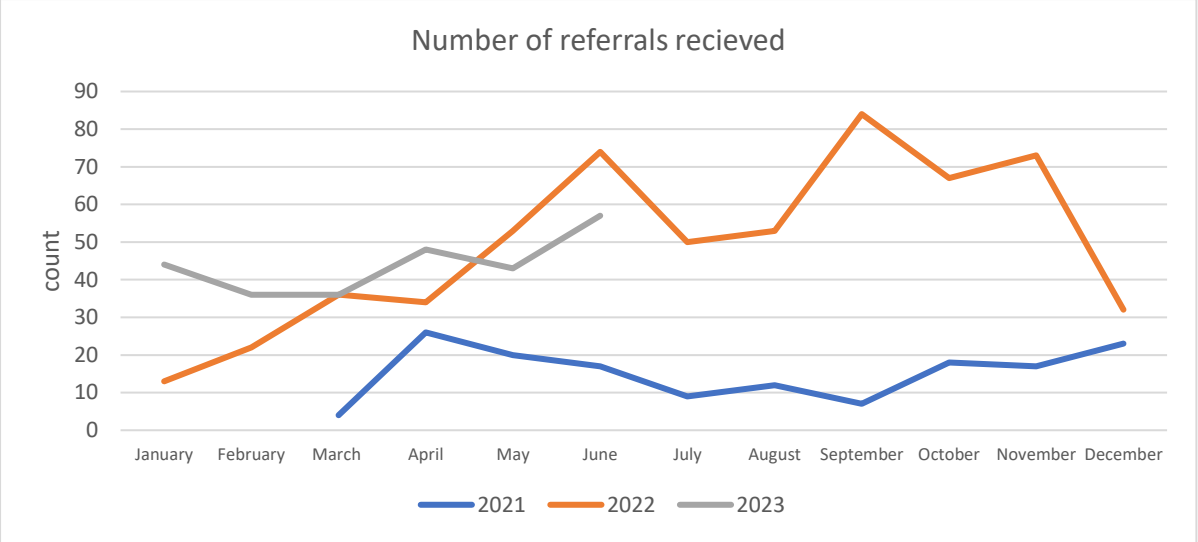

Figure 21 - total number of referrals to the Homeless and Rough Sleeper Nursing Service each month since March 2021 until June 2023

Most referrals to the Homeless and Rough Sleeper Nursing Service are self-referrals when staff attend venues. Staff within the team recognise there is a cap on how many referrals a small team can accept or find due to this, believing referrals would accelerate were the team to attend venues more regularly.

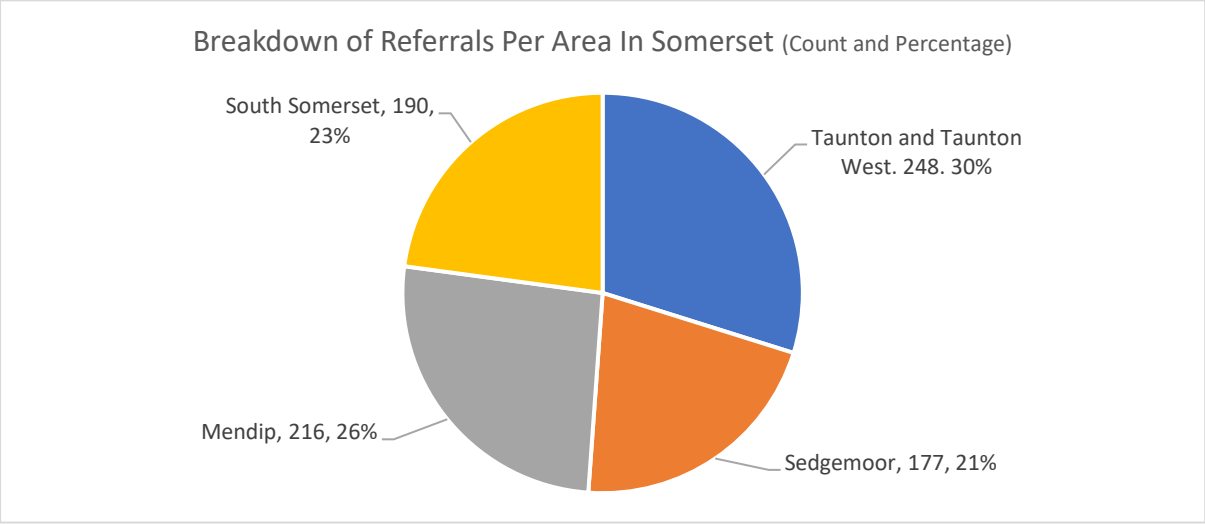

Figure 22 – Breakdown of referrals Homeless and Rough Sleeper Nursing Service per area in Somerset

The most common reason for referral to the team was physical health (75%), followed by mental health (15%).

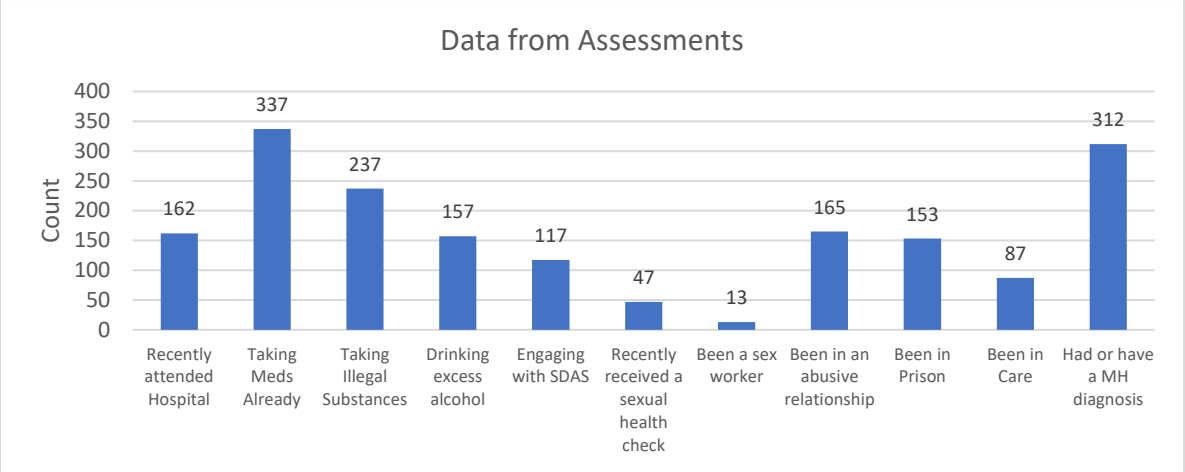

Figure 23 - Data recorded from Homeless and Rough Sleeper Nursing Service forms – shows the complexity and range of needs individuals present with, most commonly 'Taking medication already' and 'had or have a MH diagnosis'. April 2022 – June 2023

3.9.2.2 Inclusion Health Outreach GP approach – Somerset

Somerset ICB currently fund two part-time GP posts – hosted by PCNs in Taunton and Yeovil, covering 2 sessions (1 day) per week. In addition, there is temporary funded Inclusion health Outreach GP post funded for 12 months in the Mendip area (Somerset (East) providing 3 sessions (1.5 days) a week.

Data for the Specialist Outreach GP offer is show below:

Taunton Inclusion Health and Homeless GP:

In the period August 2022 to August 2023 the weekly clinics held at:

- The Reach Centre (Hostel surgery) - 419 appointments (Most appointments are residents, but some clients also attend from satellite homes, a veterans' hostel or are rough sleeping).
- Open Door Day Centre Drop-In, 176 appointments

During clinics GP also links in with staff, rough sleeper initiative workers, SDAS workers, smoking cessation clinic and homeless nurses.

Yeovil Homeless Hub - The Gateway:

In the period of 1 April 2022 – 31 December 2022 the Yeovil homeless hub saw on average 10.7 patients per day (averaged over a 32-day period):

- There were 100 new patient appointments (with length varying from 10 – 90 minutes, generally being approximately 30 minutes)
- There were 245 follow up appointments.
- 27 onwards referrals
- There were 121 different physical and mental health problems experienced in this group in Yeovil. These include, for example: domestic violence, depression, groin abscess, head injury, hypertension, leg ulcers, PTSD, trench foot and malnutrition.

Mendip Inclusion and Homeless Health GP:

In the 6-month period of October 22 to April 23:

- 71 new patients
- 91 follow up appointments.

- 162 appointments in total, all outreach or telephone appointments
- Using homeless/temporary accommodation/sofa surfing codes in GP notes
- 12 referrals to secondary care
- <5 serious child safeguarding referrals
- 9 unregistered patients
- <5 GP registrations facilitated.

Current and future plans:

- Establishing drop-in clinics in Glastonbury, Frome, Street, Shepton
- Health check clinic at Frome Traveller site
- Continue to offer vaccination and BBV screening.
- Pop up Fibroscan clinic

A map of the locations of both GP, and nursing team outreach across Somerset can be found in appendix 3.

3.9.2.2.1 *Combined (Multidisciplinary) Approach - Recognition*

At the NHS Parliamentary Awards held in London in July 2023, to coincide with the NHS 75th birthday, the NHS Parliamentary Awards announced that this multi-disciplinary outreach approach under the heading '**Homelessness Health in Somerset - the Homeless and Rough Sleeper Nursing Service and Salaried Inclusion Health GP's (NHS)'** was a winner in the Health Equities category.

Alongside the announcement the awards body had the following to say:

*"Specialist GPs Lisa and Laura together with Karen and her NHS team of 13 Physical and Mental Health Nurses, Health Link Workers and Peer Support Workers**,** are the vanguard of "Homelessness Health in Somerset" – working closely with Public Health, Accommodation providers and the VCFSE they have come together to deliver an exceptional health and wellbeing offer for this incredibly vulnerable cohort of adults in Somerset."*

Furthermore, at the 2022 Health & Wellbeing Awards, where Somerset was a Health Equity Finalist, the Royal Society for Public Health recognised the approach taken to addressing homelessness and homeless health in Somerset as best practice. The assessors were impressed by the health and wellbeing approach to homelessness in Somerset and especially the scale of the activity undertaken and the passion of its members, who clearly want to make a difference.

This national recognition shows clear support for the multidisciplinary approach taken to Homeless Health in Somerset.

3.9.2.3 Primary Care Networks (PCN)

In 2022 five Somerset PCNs identified Homelessness as their Inclusion Health priority through the NHS Directed Enhanced Service.

A practice participating in the Network Contract DES must enter into a variation of its primary medical services contract to incorporate the provisions of this Network Contract DES Specification.

The provisions of that Network Contract DES Specification, therefore, become part of the practice's primary medical services contract.

Of the five PCN's only one is yet to implement any additional activity:

- Tone Valley – ICB funded Specialist Outreach GP linked to this PCN.
- Yeovil – ICB funded Specialist Outreach GP linked to this PCN.
- Mendip – Short-term funded Specialist Outreach GP (Until Oct 2023) linked to this PCN.
- West Mendip - Short-term funded Specialist Outreach GP (Until Oct 2023) linked to this PCN.
- CLICK – No plan implemented in 2022/2023 - There is a plan for 2023/2024 and this PCN is now linked with the Homeless and Rough Sleeper Nursing Service with a named GP point of contact.

3.10 Deaths of Homeless People:

The Office for National Statistics (ONS) use capture-recapture modelling to calculate at the England and Wales (combined) level the estimated deaths in the homeless population (this modelling becomes less reliable at smaller level geographies). Sex and age breakdowns of estimated deaths of homeless people registered in 2021 in England and Wales are shown in the figure below. Males account for the majority of deaths - 87.3% male deaths, compared to 12.7% female deaths, this is consistent with previous years.

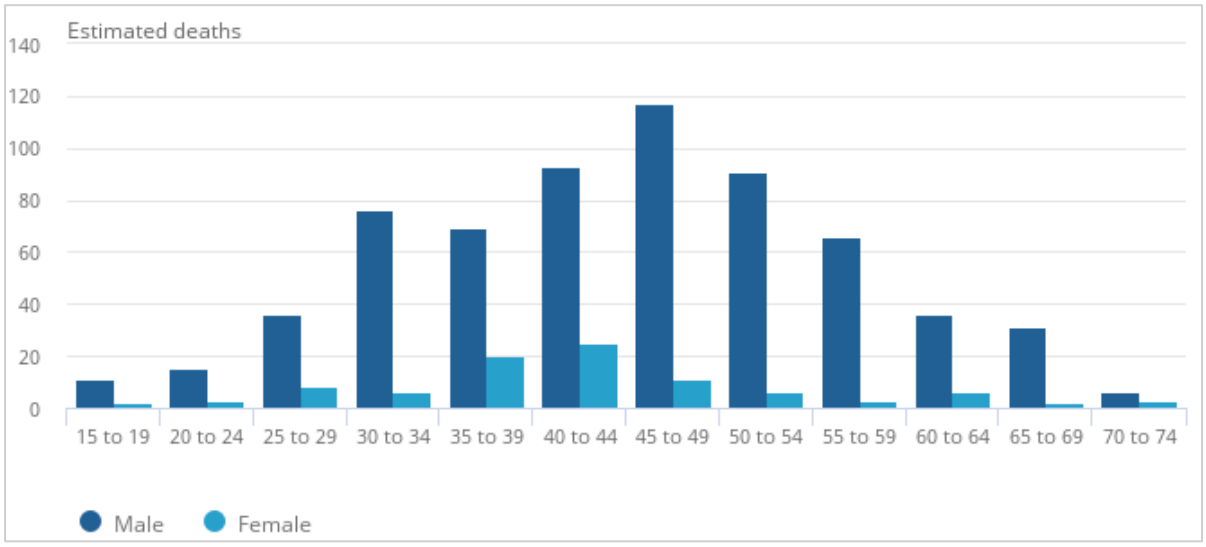

Figure 24 - Deaths of homeless people (estimated) by sex and age group, deaths registered in 2021, England and Wales – Source: ONS. There were seven times as many males' deaths compared with females in 2021.

The highest numbers of estimated deaths were seen in individuals aged 45-49 (in men) and 40-44 (in women). There has been no significant change in the numbers of deaths in the homeless population nationally since 2018, however since 2013 there has been a 53.7% increase in estimated deaths among homeless individuals[66].

For a breakdown by region (or below the England and Wales level) the same ratio of identified deaths to estimated deaths as was calculated for England and Wales is assumed; thus cation is advised in the interpretation of these figures, It is estimated that in the South West, there were 73 deaths identified in the homeless population in 2021.

ONS data presents that the drug poisoning, suicide, and alcohol-specific causes account for over half of deaths of homeless individuals (2021, in England and Wales). As per the figure below, drug poisoning is the most common of these three causes.

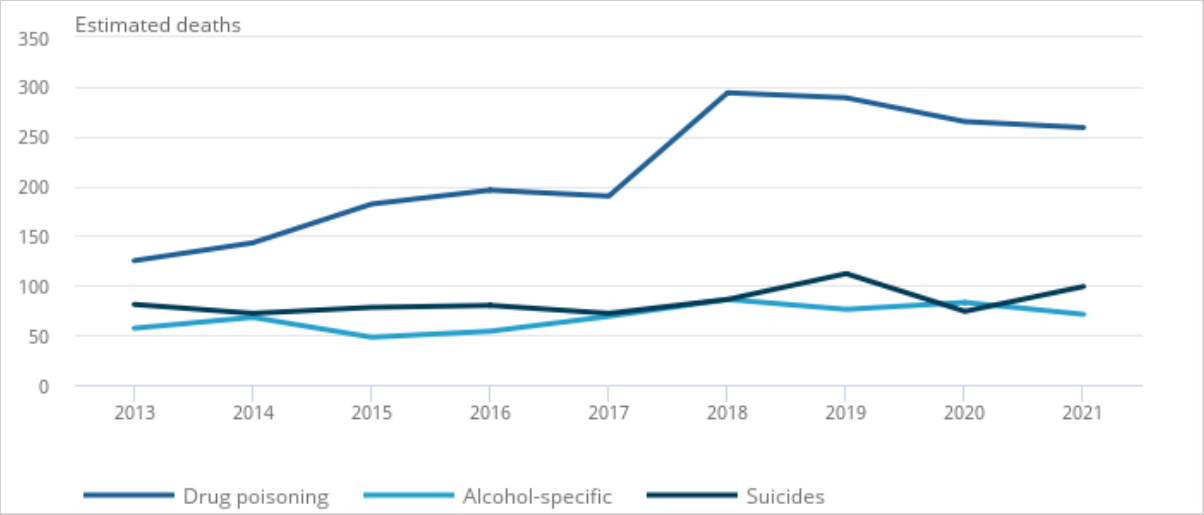

Figure 25 - ONS - Deaths in homeless people (estimated) by selected causes of death category, persons, deaths registered between 2013 and 2021 in England and Wales[67]

Additionally, a study published in 2019 showed that a third of hospital in-patient deaths among people experiencing homelessness (based of hospital admission records, and mortality data) were due to conditions such as tuberculosis, and gastric ulcers which are amendable to timely and effective health care[68]. A study comparing deaths in homeless people to a similar group of housed people, in terms of age and sex, in the lowest socioeconomic category but who had a home, based on data of 3,882 individual homeless hospital admissions, linked to 600 deaths found that:

- those in the homeless group were twice as likely to die of strokes as the poorest people who had stable accommodation.
- those in the homeless group were more substantially affected by cardiovascular disease as a whole.
- the top 3 underlying causes of death in homeless health and care schemes were: external causes of death (22%), cancer (19%) and digestive disease, such as intestinal obstruction or pancreatitis (19%)[69].

3.10.1 Recording Deaths of Homeless adults in Somerset

There is national recognition that the approach to recording deaths of homeless adults and understanding the cause of death needs to be improved – national insight and local anecdotal evidence suggest that current processes are neither reliable nor robust.

The first official estimates of the number of deaths of homeless people in England and Wales, published by the Office for National Statistics (ONS) on 20 December 2018, covered deaths registered in the years 2013 to 2017. They have produced annual reports since that time with a developing methodology.

Data provided by the ONS identified 28 deaths in Somerset using information supplied on the death certificate[70]. Deaths registered from 2017 to 2021, are presented in the figure below.

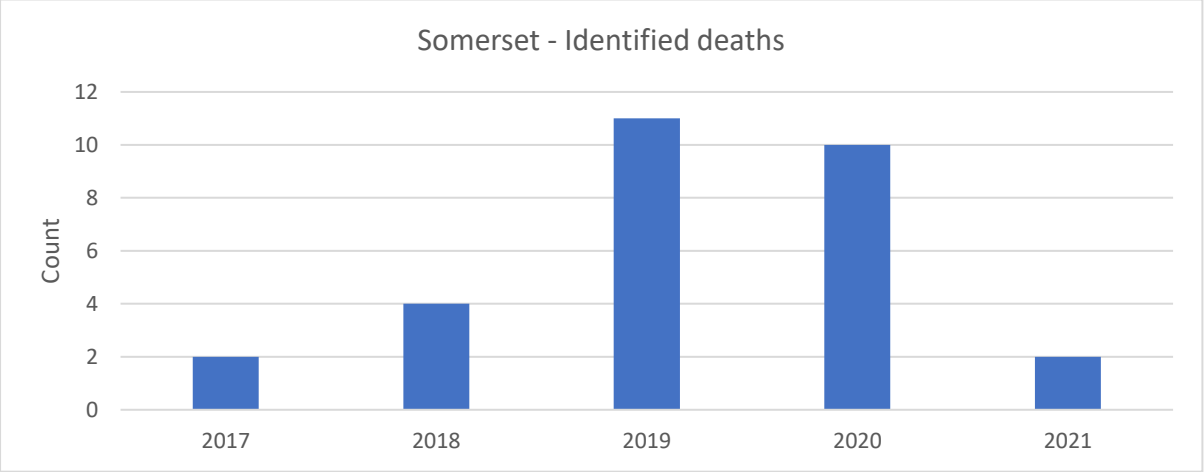

Figure 26 - Identified deaths of homeless people by year of registration, Somerset - E10000027, 2017 to 2021 (ONS).

Of these identified deaths of homeless people in Somerset the most common causes were identified as: drug poisoning (count 9), suicide (count 6), and alcohol-specific deaths (count 5).

In their annual report the ONS[71] state that deaths of homeless people are often from causes that require an investigation by a coroner, including drug poisoning and suicide. For identified homeless deaths registered in 2021, 85.2% were certified by a coroner (although only 54.8% of these actually occurred in 2021). The median delay between the date a death occurred, and the date of registration was 160 days.

The coroner for Somerset reported that, based on the information they hold, there were no deaths of individuals identified as NFA, homeless or rough sleeping referred to them in the 12 months from March 2022 – March 2023.

To gain additional insight into deaths amongst the homeless population in Somerset we canvassed a range of sources working with this population across the county - which included accommodation providers, GPs and the Homeless and Rough Sleeper Nursing Service. Analysis of the feedback received has provided us with an estimate of 24 deaths since April 2020, 9 of these in the 12-month period of March 2022 – March 2023. The most common causes of death reported were suicide and overdose.

The 2022 Guidance for doctors completing medical certificates of cause of death in England and Wales states that deaths due to acute or chronic poisoning, by any substance, and deaths involving drug dependence or misuse of substances other than alcohol and tobacco must be referred[72],[73].This would suggest that some of the deaths amongst this cohort should have been referred to the coroner and that more work is required locally to understand whether those deaths were indeed referred but not subsequently recorded as being from the homeless cohort.

3.10.1.1 Homeless Mortality Review

The Government's Rough Sleeping Strategy (2018) recommended that investigation takes place when there is a death, or an incident of serious harm, of a person who is sleeping rough to improve oversight. That Rough Sleeping Strategy suggested Safeguarding Adult Boards follow the review process of a Safeguarding Adults Reviews (SARs) in the case where a person sleeping rough has died, and there is a concern that partner agencies could have worked more effectively to potentially prevent this incident. This will offer the unique

opportunity to take vital learning and implement action to better support the strategies for reducing homelessness, and as a result preventing homelessness fatalities.

In 2020 The Local Government Association provided further guidance on the strategy recommendation having noted that whilst some Safeguarding Adults Boards (SABs) had undertaken or commissioned SARs into a death or number of deaths of people experiencing homelessness other SABs had considered referrals but concluded that the SAR criteria were not met (The adult must appear to have/have had care and support needs as defined by the Care Act 2014).

The LGA recognised that the question of whether or not the deaths of people who are homeless meet the SAR criteria illustrated the complexity of the relationship between adult safeguarding, adult social care and homelessness.

Whilst not everyone who is sleeping rough or living in a hostel will have care and support needs, as defined by the Care Act 2014, and be eligible for adult social care and/or adult safeguarding, there is considerable overlap (See 3.6.1 above)

In November 2020 there was significant media around a review into a series of deaths amongst the homeless cohort in Oxfordshire – recommendations included establishing a "homeless mortality review process" to ensure that deaths are reviewed by a multi-agency group of specialists in future.

In July 2023 the Independent Chair for the Somerset Safeguarding Adults Board (SSAB) agreed to support the development of a **Homeless Mortality Review process** in Somerset. This will need system wide support and the final proposal will be put before the SSAB, Homeless Reduction Board and finally the Somerset Board later in 2023.

4 Key Risk Factors for homelessness and rough sleeping

Key risk factors are precursor/determinant of an outcome which in this case are factors which put an individual at an increased likelihood of becoming homeless.

This section considers mental health, the impact of ACEs and trauma, vulnerable migrants, Gypsy, Roma and Traveller communities, individuals who have experienced domestic abuse or sexual exploitation, people in contact with the justice system, and veterans – those within these groups have all been shown to have an increased risk of homelessness. In the main these will be people who may sit within what is termed an 'Inclusion Health Group'.

Inclusion health it is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes[74].

The NHS Core20PLUS5 strategy identifies those experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups as Inclusion Health Groups.

The Population Health Transformation Management Board has identified Homelessness, and Coastal Communities as priority areas within the Somerset Core 20 Plus 5 strategy[75]. The needs of the homeless population overlap considerably with other inclusion health groups.

Inclusion health Groups: NHS England » Inclusion health groups

It is therefore important to consider and understand these groups and factors for effective early prevention.

4.1 Mental Health

In Somerset, the prevalence of common mental disorders is increasing among the whole population, which is mirrored by an increase in anti-depressant prescriptions and demand for mental health services. Additionally, Somerset is a consistent outlier for rates of suicide and self-harm. Suicide rates in Somerset are higher than nationally and are showing an increasing trend. Rates are consistently higher in males, in line with the trend seen globally. Hospital admission rates due to self-harm are consistently higher than nationally, with the rate in Somerset highest for young people aged 15-19 (for more information on the picture of mental health in the wider Somerset population, see the Somerset Mental Health Needs Assessment: Mental Health Needs Assessment 2023.pdf (somersetintelligence.org.uk)).

In the South West (England) region, of those households (including single people living alone) who are owed a housing prevention or relief duty, the most common health history is a 'history of mental health problems', followed by 'physical ill health and disability', 'history of repeat homelessness or rough sleeping', 'at risk of or has experienced domestic abuse' and 'offending history', this is echoed in the Somerset population as can be seen in the graphs below (for a full break down by district see appendix).

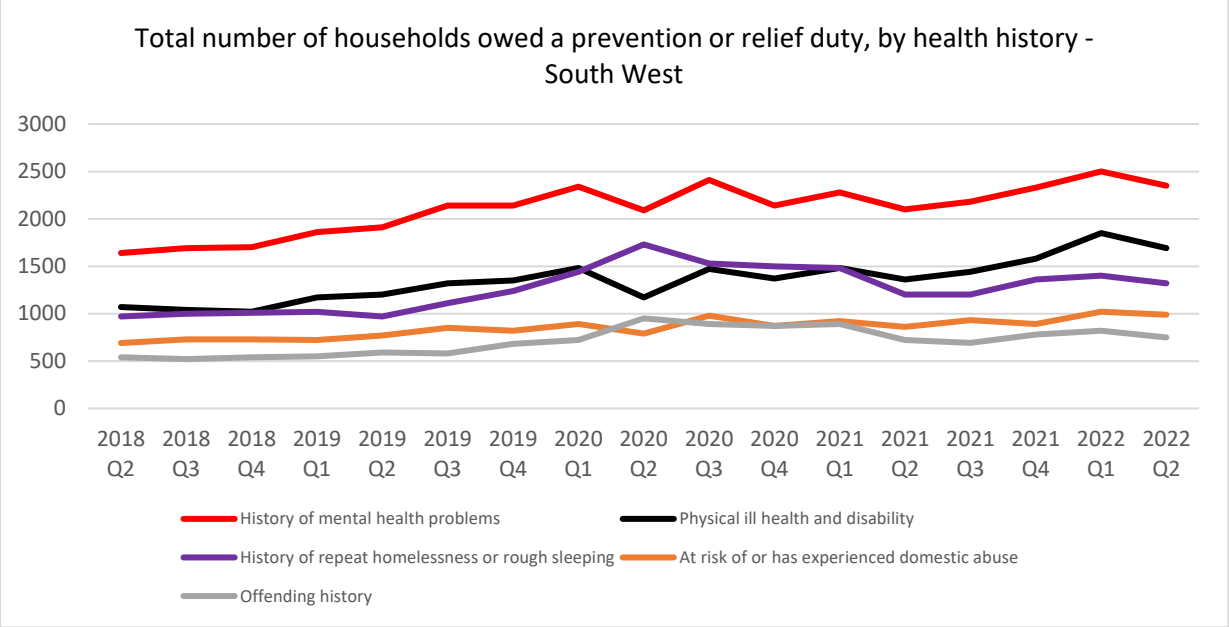

Figure 27 - total number of households owed a prevention or relief duty, by health history. South West Region. Source: SHARE

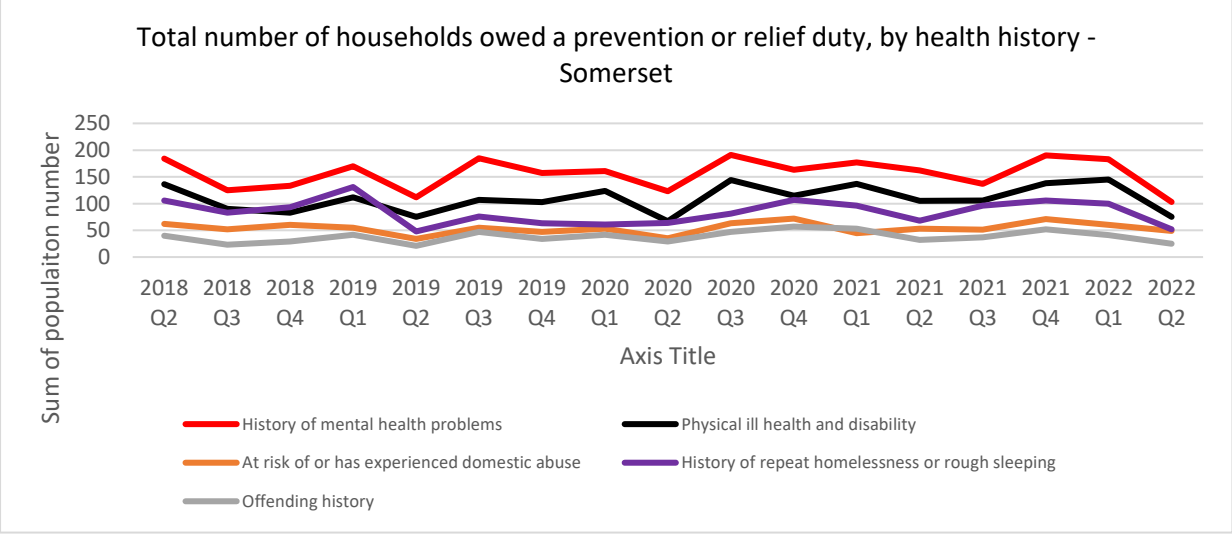

Figure 28 - total number of households owed a prevention or relief duty, by health history. Somerset. Source: SHARE[76]

In the Homeless Health Needs Audit – the unhealthy state of homelessness, 'Admitted to hospital because of a mental health issue' was the second most frequent life experience and risk factor identified – this is shown in the figure below.

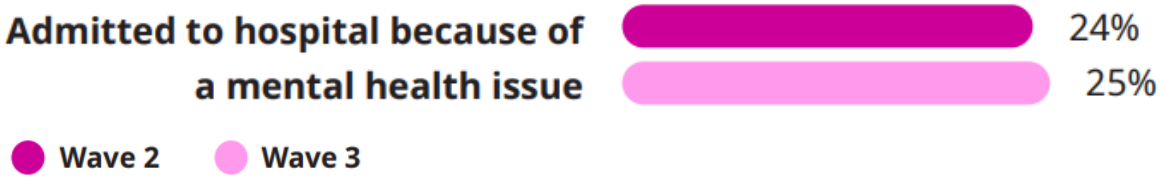

Figure 29 - Life Experiences and Risk Factors associated with homelessness. (Wave 2 (2015-2017), wave 3 (2018-2021)). Source: Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)

4.2 Children and Young People

4.2.1 Recognising the impact of ACES/Trauma on future predicted health needs.

The evidence base around how the impacts of trauma and adversity in early life can be long-term predictors of poor health and wellbeing outcomes has increased over time and is considered in this section.

Adverse childhood experiences (ACEs) have been found to have significant lifelong impacts on both behaviour, and health outcomes. ACEs are potentially traumatic events which occur in childhood, these can include but are not limited to experiencing or witnessing violence, abuse or neglect, living in a household with substance abuse issues or instability due to parental separation or household members being in jail[77]. ACEs are interrelated, so if one ACE is reported this increases the chance of reporting at least one more. In the UK population 47.1% reported experiencing at least one ACE[78]. Increasingly ACEs have been linked to adverse behavioural, health and social outcomes.

The prevalence of ACEs is considerably higher amongst homeless adults when compared to the general population, with approximately 9 in 10 homeless adults having experienced at least one ACE, and over half being exposed to over four ACEs[79]. In Somerset during 'Everyone In' (April 2020) extended interviewing with homeless population found that 58% or respondents reported childhood abuse or neglect.

Significant research conducted by Public Health Wales (2019)[80] reported the correlations between homelessness and ACEs. Some extracts have been included below:

"Homelessness in youths and adults is one of the negative effects that has been associated with adversity in childhood, where homelessness in adults is more likely amongst those who have experienced a history of childhood adversity and poverty. In particular, homelessness in adulthood has been associated with individual risk factors experienced in childhood such as parental addiction, domestic violence (DV), and living in social housing or local authority care as a child. Family relationship problems and lack of support networks are common amongst teenagers and young adults who find themselves homeless."

"The national Welsh ACE study found that 14% of adults had experienced four or more ACEs. There has been growing evidence in the past two decades that exposure to ACEs early in life has long-term impacts on health, wellbeing, and behavioural issues and that many of these conditions and outcomes could have been alleviated if toxic stress caused by ACEs was addressed in childhood."

"A systematic review found that ACEs are risk factors for many health conditions in adults, but the associations were particularly strong for violence, substance misuse, problematic alcohol use, and mental illness, which are also factors associated with homelessness. The systematic review also highlighted a consistency between studies, in the links between exposure to multiple ACEs and poor health, despite variations in type and extent of exposure."

"Homelessness is a late emerging symptom in those experiencing deep social exclusions, including institutional care, substance misuse, or participation in street culture activities. With ACE-prevalence extremely high in this population, suggesting that homelessness is a symptom of a life-pathway that is influenced by a range of known variables. Where exposure to social disadvantage in childhood leads to being less likely to adapt successfully and more likely to adopt unhealthy coping behaviours."

4.2.2 Pathways to independence (p2i)[81]

Somerset Council work collaboratively with housing and support providers: YMCA Brunel Group, and YMCA Dulverton, to deliver Pathways to independence (P2i). The P2i service provides support for homeless and vulnerable people aged 16-25, and can support with[82]:

- Emergency Accommodation
- Time to Talk – mediation to help to rebuild connections.
- Supported Accommodation
- Support in finding housing, maintaining accommodation, helping with benefit claims, setting up utilities, managing money etc.
- Tenant Accreditation Scheme – to help give young people the knowledge and skills they will need in order to live independently.
- Partnership working – close working relationships with colleagues in Children's Social Care and other agencies.

Of the 165 individuals involved in analysis of P2i service users, 50% were female, 45% male, 1% transgender, and 4% unknown. 50% of these individuals had experienced being in care, and 56% of these individuals had a history of being homeless or vulnerable housed.

The most common health and care need amongst the P2i service users was mental health (89%), followed by drug use (41%), learning disability (28%), physical health (24%), alcohol use (23%), sensory disability (9%), personal care (8%), and physical disability (6%). Mental health was more commonly cited as a health and care need in females (93%) compared to males (81%), drug abuse however was seen more in males (45%) than females (39%).

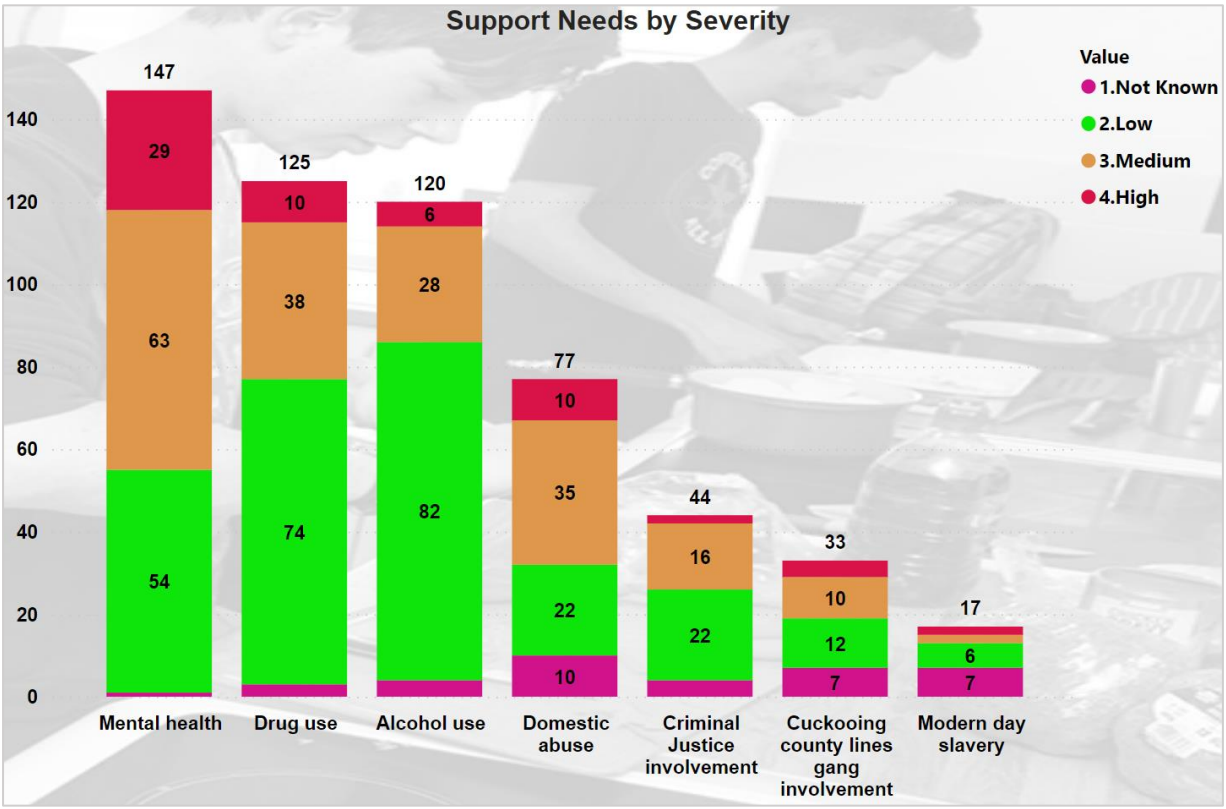

Figure 30 – Somerset P2i, support needs by severity (for more information on categories of support see appendix)

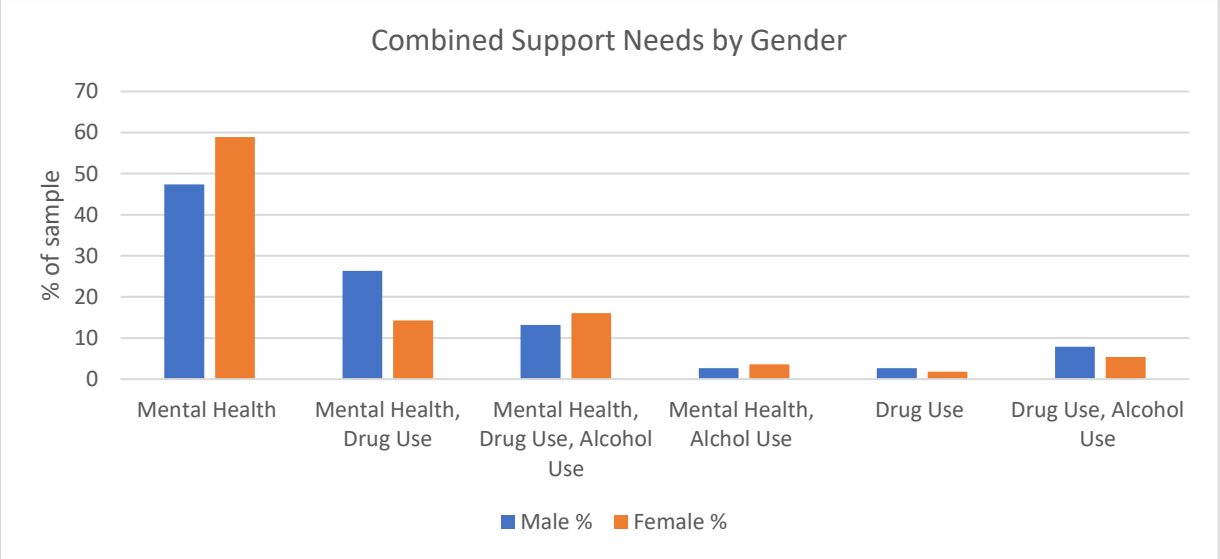

Figure 31 – Somerset P2i Combined Support Needs by Gender

As shown in the figure above mental health was the most commonly support need seen in both males, and females, followed by mental health and drug use for males, and mental health, drug use, alcohol use for females.

Residents typically took 3-6 months to move on, followed by 6-12 months; with the most common anticipated move on solutions being described as 'general needs with initial support'.

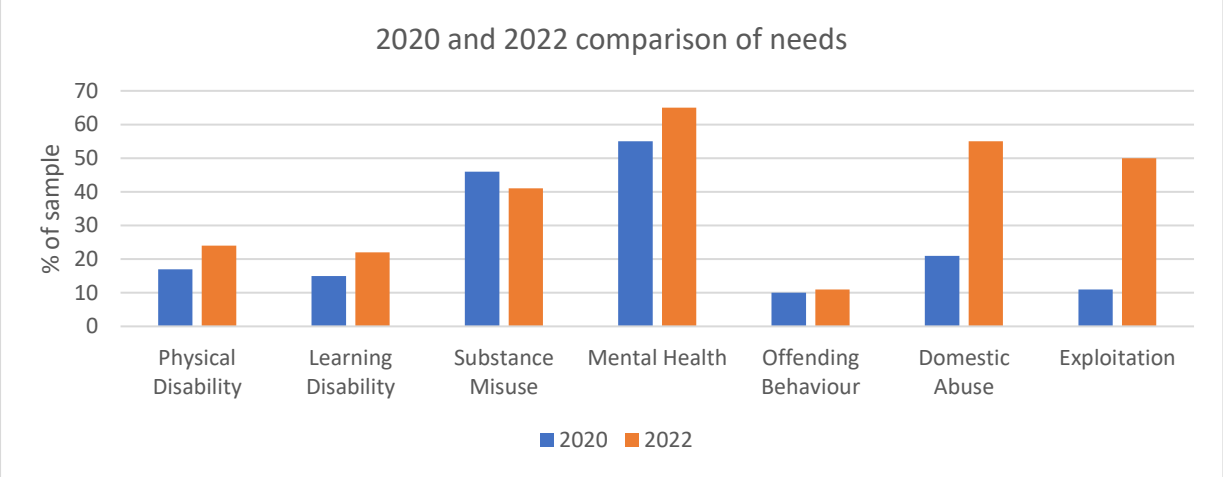

Figure 32 – comparison of needs 2020 – 2022 – Somerset Council CSC

Comparison of support needs from 2020 versus 2022, shows there has been an increase in all categories except substance misuse, with the most significant increases seen in domestic abuse and exploitation.

Mental health however remains the most prominent support need.

A data snapshot (August 2022), including a total of 184 young people aged 16-25 outlines the needs in a range of placements in Somerset who are supported by Children's Social Care compared to those who have no Children's Social Care involvement. As part of a 16+ data return providers, Social Workers and Leaving Care Workers were asked to undertake a snapshot activity of all 16+ young people in a range of provision across Somerset on 15.08.2022 to identify support needs for this cohort. The data in the graphs below is from 138

– P2i, 12 – 16+ spot purchase placements, 14 – in house leaving care accommodation, 12 – stepping stones, <5 - residential, 6 – fostering/staying put.

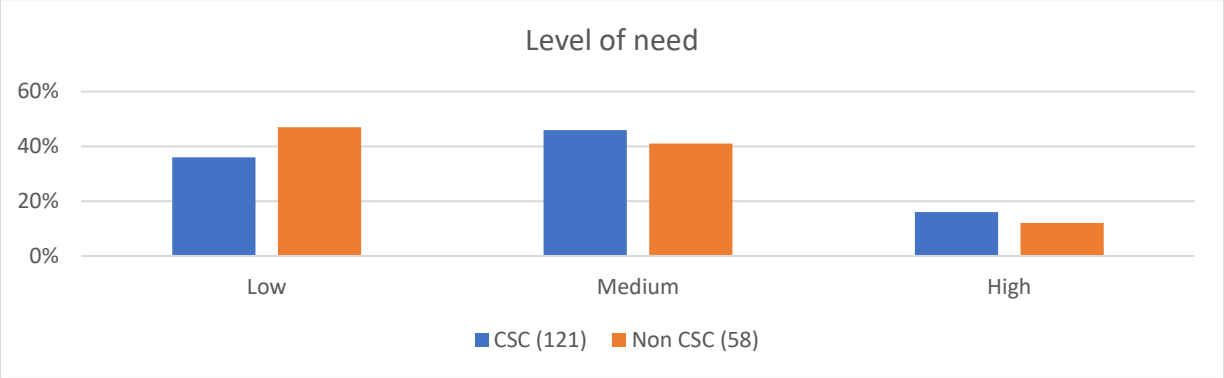

Figure 33 – Level of need – comparison between CSC and non-CSC

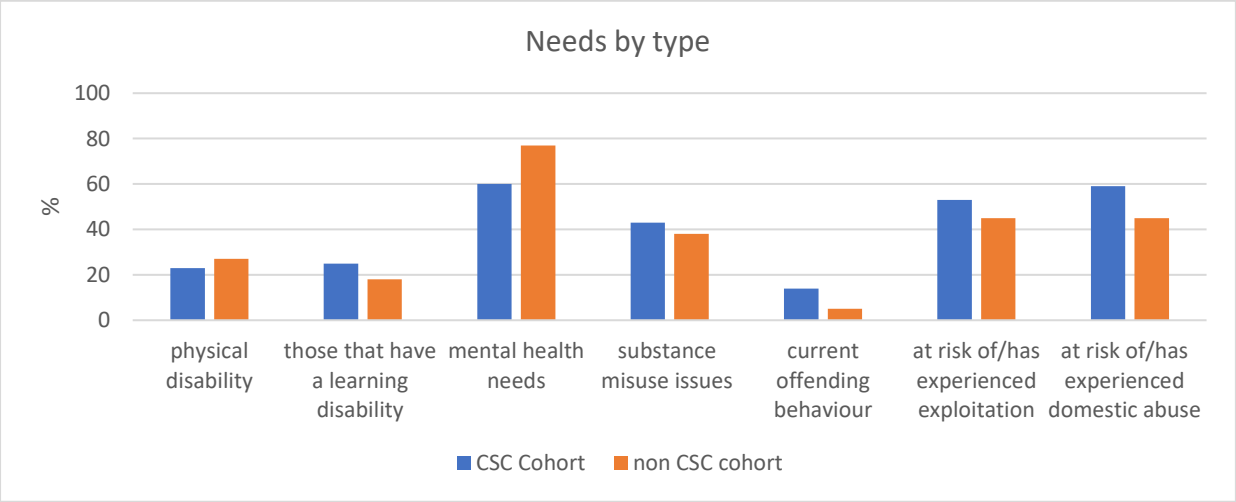

Figure 34 – Needs by type – comparison between CSC and non-CSC.

4.3 Vulnerable migrants, Gypsy, Roma and Traveller communities

Vulnerable migrants can include, but is not limited to: unaccompanied children, ethnic minorities, individuals working in the informal sector. Asylum seekers and refuges are also groups of vulnerable migrants[83]; refugees are individuals who has been forced to flee persecution, war or violence and has crossed an international border to find safety in another country, refugees are afforded international protection by other countries as it is too dangerous to return home, An asylum seeker is an individual whose request for sanctuary is not yet processed.

Securing housing for asylum seekers in the UK is the responsibility of the Home Office, however once granted leave to remain it is expected that asylum seekers who are granted refugee status find accommodation in 28 days. Individuals leaving Home Office accommodation may not have sufficient funds to secure private rented housing without additional help; asylum seekers are not permitted to work, thus saving for a deposit may act as a barrier. Additionally processing benefit applications can take longer than 28 days. Furthermore, it can take time to receive a National Insurance number – this can delay entry to the workforce.

These factors can put refugees at an increased risk of homelessness[84]. The percentage of homeless households with a recorded support need indicating one or more individuals is a former asylum seeker (2021/22) is 1.2%, this is the same in households with and without children[85].

We can expect to see an increase in the population of refugees and asylum seekers in Somerset over the short term as the conflict in Ukraine continues and due to national changes to asylum policy in Spring 2022. This could have an impact on sustainable housing and demands for mental health services.

To date over 1900 refugees and asylum seekers have been placed in Somerset since 2016. Before August 2021, the local authority participated in the Vulnerable Persons Resettlement Scheme (VPRS) and supported approximately 130 refugees impacted by the conflict in Syria, a breakdown of nationalities can be seen in table 6. Over the last 18 months there has been a 16x (+) increase in the number of displaced people in the county; increasing from approximately 130 in August 2021 to approximately 1900 in January 2023. This is linked with the evacuation of Afghan personnel and citizens, the war in Ukraine and the increase in small boat crossings.

Table 9 – Number of Asylum Seekers and Refugees in Somerset to 2023

Scheme/Nationality	**Age**	**Number** (rounded to nearest 10)
VPRS Scheme including (Syrian and Kurdish refugees)	Adults	50
	Under 18s	50
Community Sponsorship refugees (Syrian, Palestinian, and Kurdish refugees)	Adults	<20
	Under 18s	<10
ARAP/ACRS schemes (Afghans)	Adults	<20
	Under 18s	20
Homes for Ukraine (HfU) (Ukrainian Nationals)	Adults	880
	Under 18s	530
Unaccompanied Asylum-Seeking Children (UASC) **(Variety of nationalities primarily Kurds)**	Care Leavers Under 18s	Total to-date = 60 Number of over 18s outside of Somerset: 20 Number outside under 18 outside of Somerset: <10 Numbers of Under 18s are continuing to grow with our current figure allocated by the Government as 120* under 18's. *This is the number of UASC the LA could be allocated, not the number currently placed.
Adult Asylum **25-30 nationalities represented**	Single adults, couples and families	Approx 280

Research from Crisis UK[86] identified that EEA citizens living in Britain are almost twice as likely to experience the worst form of homelessness, as well as being approximately 3 times more likely to experience sleeping rough – this is caused by similar reasons as homelessness in

British nationals but is compounded by the limited support that some European Union citizens can receive.

4.3.1 Gypsy Roma, traveller populations

In Somerset 0.1% of the population is 'White: Gypsy or Irish Traveller', highest in Mendip (0.2%). Additionally, 0.1% of the Somerset population is 'White: Roma', the same in all districts[87]. This may be an underestimate of these populations, the 'Women and Select Committee' report on the inequalities faced by Gypsy, Roma and Traveller communities noted that people in these groups may be reluctant to self-identify, even where the option is available to them. This is because Gypsy, Roma and Traveller people might mistrust the intent behind data collection[88].

Support needs for the homeless are difficult to specify, as it includes individuals who may be unsafely, unstably, or insecurely housed. For example following concerns in relation to exploitation and modern slavery the Public Health team in Somerset initiated a multi-agency response with a range of national and local partner organisations in relation to a population of migrant Roma adults and children who were found to be residing in poor quality accommodation, with little access to health care or wellbeing support, having travelled to the UK for employment. This population is considered extremely vulnerable in relation to both health and wellbeing, and exploitation. The Homeless and Rough Sleeper Nursing Service and Public Health Nursing Team are supporting this population as part of a wider programme of activity to raise standards and reduce the risk of harm and poor health outcomes.

4.3.2 Van Dwellers

'Van life' is a growing social movement gaining popularity worldwide as an affordable nomadic lifestyle choice. In the UK a number of localities are experiencing rising numbers of van dwellers, who would otherwise be homeless, living on the roadside.

In Somerset this is particularly evident in Glastonbury, a rural town, with a population of approximately 9,000 residents. Relative to the size of the town there is a large population of approximately 250 – 300+ travellers and van dwellers including several settled traveller communities in Unauthorised Encampments (UE). Numbers have increased significantly since Spring of 2020 (Covid-19 pandemic) mainly on the roadside.

People living in encampments or by the road are generally living without running water, sanitation, power, refuse collection and adequate safe space at their location. This presents multiple issues such as health and wellbeing, safety and communication (especially digital).

Research conducted (February 2020) by the Community Council for Somerset on behalf of Mendip District Council found that at that time 10% of roadside dwellers who responded to a survey had been rough sleeping. This figure may increase with anticipated economic pressures and loss of employment. Outreach activity in relation to housing options support found that of the first two van dwellers engaged with both were vulnerable and fell into the category of homeless with a history of van dwelling sofa surfing and in one case rough sleeping.

Whilst van dwelling is not referenced in the definition for Rough Sleepers it does include; *People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters often comprised of cardboard boxes).* As these are generally repurposed vehicles or very old touring caravans, neither of which were intended or equipped for long term habitation, it is reasonable to include this cohort in our assessment and data set.

The Housing team for Somerset Council (East) has produced indicative data of the van dweller cohort in the Glastonbury area. They estimate that 246 adults excluding children (approx. 197 households) are currently occupying 236 lived-in vehicles at the roadside or in unauthorised encampment (UE) on fields adjacent to the public road (such as at Porchestall Drove). The breakdown of the households is based on data from research in 2019 –20. Whilst there is no formal census of children within the cohort it is believed that very few children live with their parent in a lived-in vehicle. In addition to those at the roadside or within UE adjacent to the roadside there are also UEs on private land within 2 or 3 miles of Glastonbury. When these populations are considered together the estimate is that 305 adults excluding children (approx. 244 households) are currently occupying 285 lived-in vehicles - as of August 2023 (see figure below).

Both sets of figures are conservative estimates as the data does not include numerous other encampments spread around Glastonbury and its immediate vicinity, nor every individual lived-in vehicle situated on the street, as the housing outreach team only collate data for hotspots or where there has been a complaint.

4.4 Experienced Domestic Abuse or sexual exploitation

Of all homeless households those with a recorded support need indicating one or more individuals is at risk of/has experience of sexual exploitation and/or abuse 11.7% was at risk of/experiences domestic abuse, 3.0% non-domestic abuse, and 2.3% sexual exploitation/abuse. The numbers experiencing domestic abuse was higher in households with children (16.3%), as is shown in the figure below.

Percentage of homeless households with a recorded support need indicating one or more individuals is at risk of/has experience of abuse and/or sexual exploitation, 2021/2022.

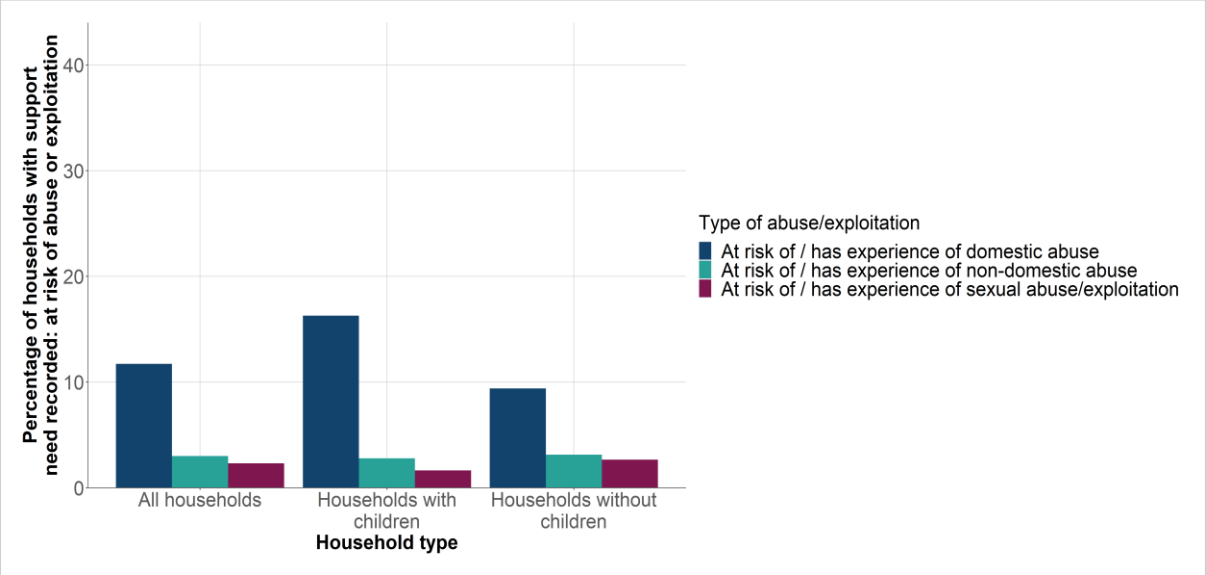

Figure 35 - Office for Health Improvement and Disparities (2022) Spotlight indicator SP250 - https://analytics.phe.gov.uk/apps/spotlight/

In Somerset the Homeless Audit records 12/38 (31.6%) of individuals recorded as having previous experience as being a victim of domestic abuse, additionally <5 individuals were a victim of trafficking/slavery (2021/22). Additionally in 2020 interviews <5/19 highlighted domestic abuse.

Out of 6 factors identified in the Homeless Health Needs Audit – the unhealthy state of homelessness 'been a victim of domestic violence' was the 3rd most common, following having spent time in prison, and a mental health hospital admission. Additionally in 2021 Somerset Vulnerabilities Pathways research identified that 20% of homeless respondents had been a victim of domestic violence.

Figure 36 - Life Experiences and Risk Factors associated with homelessness. (Wave 2 (2015-2017), wave 3 (2018-2021)). Source: Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)

4.5 People in contact with the justice system (including ex-prisoners)

Somerset is among the top 10 safest counties in the UK, with a crime rate of 65 crimes per 1,000 population (2022)[89].

In the 6 months from December 2020 – May 2021, there were 19,209 reported crimes, most common offence types were 'violence and sexual offences', followed by 'anti-social behaviour', 'public order' and 'criminal damage and arson'[90].

The percentage of homeless households with a recorded support need indicating one of more individuals has an offending history (2021/22) for all household was 9.1%, this is higher in household without children (13.2%), and lower in household with children (1.1%)[91]. 11/38 individuals from the homelessness audit identified a previous experience of prison or young offenders' institute.

The Homeless Health Needs Audit – the unhealthy state of homelessness, identified 'spent time in prison' as the most commonly identified life experience and risk factor, with 35% of respondents experiencing this in wave 2, and 25% in wave 3. Additionally, having spent time in a secure unit or young offenders' institution was also identified as a risk factor, which was identified by 10% of respondents in wave 3. In the 2021 Somerset Homeless Health Needs Assessment 30% of respondents has spent time in prison.

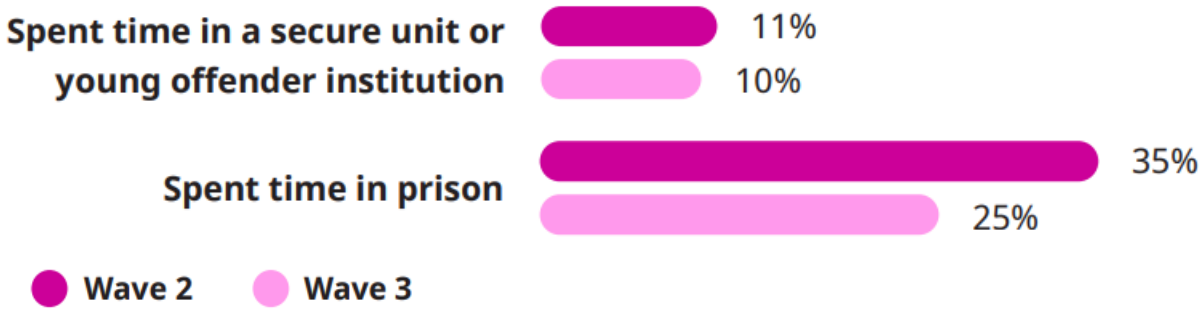

Figure 37 - Life Experiences and Risk Factors associated with homelessness. (Wave 2 (2015-2017), wave 3 (2018-2021)). Source: Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)

4.6 Veterans

The current serving personnel within Somerset stands at 3,230, across the Navy, Army and RAF, 820 reservists, and a veteran population of 43,200.

The Homeless Health Needs Audit – the unhealthy state of homelessness (as above) reported that 4% of those surveyed had spent time in the armed forces in wave 3 (2018 -2020), reducing

by 1% from the previous wave. This was the least common of the 'life experiences and risk factors' identified.

Figure 38 – Life Experiences and Risk Factors associated with homelessness. (Wave 2 (2015-2017), wave 3 (2018-2021)). Source: [Homeless_Health_Needs_Audit_Report.pdf (kxcdn.com)]

The Homefinder Somerset Equalities Report from July 2022 year includes the following data:

From applicants across Somerset who have applied or updated their application since 2 August 2021, 156 reported that they had served in the regular British Armed Forces (Army, Navy or RAF) or British Reserve Forces. This accounted for 3% of all households (See tables below). Of these applicants, 27 reported that they are currently serving in the regular British Armed Forces (Army, Navy or RAF) or left in the last 5 years (See tables below). Such applicants are exempt from the local connection requirement to register with Homefinder Somerset.

A total of 20 applicants reported that they need to move because of a serious injury, medical condition (including mental health) or disability sustained as a result of their service. Eight of these applicants reported that they are currently serving or left in the last 5 years.

Table 10 – Served in the regular British Armed Forces (Army, Navy, RAF) or British Reserve Forces

	No.	% Population
Mendip	22	2%
Sedgemoor	37	3%
Somerset West & Taunton	56	3%
South Somerset	41	3%
Total	**156**	**3%**

Table 11 - Currently serving in the regular British Armed Forces (Army, Navy or RAF) or left in the last 5 years.

	No.
Mendip	5
Sedgemoor	6
Somerset West & Taunton	10
South Somerset	6
Total	**27**

5 System Risks

5.1 Health, Wellbeing, Care: Provision and Culture

Increased focus on this adult cohort and improved provision, have led to increased case finding through examination, testing and safeguarding, together with improved delivery of primary and preventative care. Examples include wound care and facilitating appointments elsewhere across the system (delivered by the Nursing service and VCFSE).

This increased case finding, and provision is likely to be seen as additional demand on services. Over time this is likely to have an impact elsewhere in the system – whether through fewer appointments or reduced costs for acute treatment. Work is currently underway to secure a recurring annual report to update this analysis.

The development of the current homeless health offer, however, has not been consistent across Somerset due to the nature of funding opportunities and local objectives that have been pursued. Consequently, there is an inequity in specialist GP provision across Somerset. This is identified within the ICB-led General Practice Strategic Review of Health Services for Homeless Patients and is currently being considered.

In addition,

- Mental Health provision for this cohort, based on the data analysis and workforce provision is likely to be insufficient to meet the needs of the population – in particular there is still a need to develop treatment and support which fulfils the objectives of the NICE Guidance.
- The Better Futures analysis suggests that (in the view of the supported accommodation providers), 210 of the 358 residents in the main study had a need for statutory level care and support with their mental health, substance use, physical/sensory impairment, physical health and personal care needs. This highlights the ongoing issue of providing suitable safe accommodation for vulnerable adults and whether 'supported accommodation' - which is not a care setting - meets the needs of the entire cohort or whether there is a need for additional accommodation options (see 5.4 below).

Feedback from health, outreach and accommodation providers suggests that there is a need to develop more effective relationships with Adult Social Care and especially regarding the timely completion of care assessments and understanding the complexity of clients with tri-morbidity.

A report[92] into executive dysfunction within the homeless cohort and how this can impact on assessments and decision-making for adults experiencing complexity and multiple disadvantage, found that a wide range of conditions and contexts can affect executive functioning. When executive functioning is disorganised or underdeveloped, it can inhibit appropriate decision-making, reducing people's problem-solving abilities. This poses difficulties in ensuring that individuals have the capacity and or ability to act out their wishes and decisions.

> "If the outcome of your brain injury or neurodevelopmental/cognitive need is that you struggle to plan, to organise, to carry out actions that you know are in your best interests,
>
> If you struggle to remember what it was that you planned to do, if you struggle to stay on track and prioritise tasks that will help you secure or maintain accommodation,
>
> If you are impulsive, if you lack the ability to see how actions/inactions have consequences …….

Then homelessness is an obvious outcome.

It takes skills to maintain tenure and self-care, those skills are cognitive, executive, and behavioural in nature.

Those are the very skills that executive dysfunction takes away from people, and some aspects for adults with neurodivergence struggle with.

Some people of whom may have not been functioning brilliantly because of social deprivation, societal inequality, and developmental trauma.

It will be statistically very likely that 50% of the people that cannot control their behaviour have experienced at least one brain injury.”

Dr Mark Holloway BA (Hons) DipSW MA DSW

Senior Brain Injury Case Manager and Expert Witness

There remains a need to develop a system wide trauma informed workforce to identify and address risk factors linked to Adversity in Childhood at the earliest opportunity (Early Help) but also see how these factors impact on behaviours and outcomes in adulthood.

Homelessness in youths and adults is one of the negative effects that has been associated with adversity in childhood, where homelessness in adults is more likely amongst those who have experienced a history of childhood adversity and poverty. Family relationship problems and lack of support networks are common amongst teenagers and young adults who find themselves homeless. Many of these adversities are recognised collectively as Adverse Childhood Experiences (ACEs)[93].

The 2015 research by Crisis drawing on large studies on homelessness across Britain, suggests that tackling homelessness early could save the government between £3,000 and £18,000 for every person helped[94].

5.2 Financial Pressures

The (new) Somerset Council comes into existence at the most challenging time for local government in a generation. The cost of delivering our services has dramatically increased due to rising energy costs, rising interest rates and increasing numbers of people who need our support (Somerset Council Plan 2023 – 2027).

These pressures on Local Government and the NHS present significant risk. Not least in relation to:

- Workforce resilience and development – funding existing posts, retaining staff and recruiting into new roles.
- Treatment Accommodation and Support – Better Futures strategy and commissioning plan / SHAP

However, there is an ongoing commitment from central government which shows a national strategic commitment to resolving homelessness in the long-term. This is demonstrated through the Rough Sleeper Imitative (RSI), Next Steps Accommodation Programme (NSAP) and Single Homelessness Accommodation (SHAP) funding for accommodation delivered to the Housing Teams and NHS via their Health Equalities Partnership (HEP) Programme Specialist Homeless Mental Health and Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) funding.

There is a need to incorporate cost-benefit analysis for this area of delivery across the whole system. The initial analysis which supported the development of the Nursing Service articulated the cost savings that can be achieved through effective proactive primary and preventive care. This approach reduces further and ongoing treatment costs, the costs of missed appointments (DNAs) or - whilst rare - the risk of loss of limbs and the associated life-long impacts.

Homeless Health is one area where investment will impact significantly on cost and demand reduction elsewhere in the system. It is estimated that the financial cost of an individual sleeping rough in the UK for 12 months is £20,128, comparatively the cost of a successful intervention is estimated at £1,426[95]. Additionally, evidence shows that people who experience homelessness for three months or longer cost on average £4,298 per person to NHS services, £2,099 per person for mental health services and £11,991 per person in contact with the criminal justice system. It is estimated that if 40,000 people were prevented from experiencing homelessness, public spending could see an annual reduction equivalent to £370 million (based on an average estimated reduction in public spending of £9,266 per person per year)[96].

In Somerset, between 2018 and September 2020, NHS Somerset FT reported that 'there were 194 admissions across our services from patients registered with no fixed abode (only a small percentage of the total homeless patient cohort). These admissions led to 5,048 bed days. Timely discharge to appropriate housing, and care coordination may help to mitigate some of these financial impacts to health services.

Individual patients within the cohort can end up with very long hospital stays and significant medical intervention. In 2019 one patient in his late 20s was admitted and eventually had a foot amputated. The cost of his care exceeded £150,000 over an 11-week post-op care period. Earlier intervention from an assertive outreach service and the dual diagnosis team may have avoided both the amputation and the cost (An Earlier Intervention and Prevention Outreach Nursing Service for the Homeless and Rough Sleeper Population of Somerset Nov 2020).

5.3 Planning and commissioning

NHS England's National Healthcare Inequalities and Improvement Programme is collaborating with teams across the NHS and wider partners to develop a framework for NHS action on inclusion health, which will distil best practice and clarify role expectations on this agenda.

There are five draft principles which should underpin the design and delivery of services for people living in inclusion health groups:

1. Commit to action on inclusion health - Action on Inclusion Health is driven by senior leadership and supported by relevant structures and policies to ensure that it is included in all programmes of work at all levels.

2. Understand the characteristics and needs of inclusion health groups locally - Understanding the needs of people in inclusion health groups locally is essential to developing effective action. NHS bodies* should work with Local Authorities and trusted community partners to ensure that the characteristics, needs, and health and care outcomes of inclusion health groups are clearly defined for their local area.

3. Develop the workforce for inclusion health - NHS Bodies* ensure that frontline staff and team leaders have the skills needed to support socially excluded groups. This includes providing training for all staff across health, social care and VCSE organisations, with workforce development and support for people delivering specialist services.

4. Develop integrated and accessible services for inclusion health - The NHS works with wider partners to develop personalised and accessible approaches which improve healthcare, address wider determinants of health, and ensure that the needs and preferences of inclusion health groups are specifically considered when designing, commissioning and delivering services across national, regional and local systems.

5. Demonstrate impact and improvement for inclusion health - NHS bodies and partners identify and agree common outcome focused evaluation measures, involving inclusion health groups, and use this information to inform the development of policies, programmes and services.

The framework is intended to support leaders in national and regional teams as well as local systems to identify specific priority actions to tackle health inequalities faced by inclusion health groups. It will help to contextualise the agenda within current NHS priorities and provide greater clarity of roles and responsibilities across the NHS and with partners, to promote partnership working between agencies. The aim is to publish the framework in September 2023.

Ahead of this framework being published Somerset Council working together with NHS colleagues are already:

- Identified Inclusion Health Groups as a public health priority.
- Reviewed the existing Specialist Outreach Health Inclusion GP offer with an aspiration to deliver an equitable offer for this cohort across the whole of Somerset.
- Prepared to develop an overarching Somerset Homeless Health strategy to underpin the Somerset ICB NHS Core 20 Plus commitment where Homeless and Coastal Communities have been identified as priorities.
- Working with the two main hospital settings to improve the approach to this cohort both on admission and also regarding the planning around their leaving hospital to avoid people being discharged to the streets.
- Begun to deliver Inclusion Health workforce training to healthcare professionals across the system.

There is a need to ensure there are planned, integrated multidisciplinary health and social care services for the cohort[97].

5.4 Accommodation

There is a lack of access to appropriate housing to support adults with multiple complex needs resulting in a chronic shortage of suitable, affordable, single person accommodation. One size does not fit all – a range of barrier free options should be available including: Emergency, Supported (24 hour), Housing First, Treatment accommodation, Supported and Satellite accommodation. This includes an offer which meets the needs of vulnerable alcohol or substance dependant clients in non-abstinence accommodation (Managed alcohol approaches in hostel settings were successfully adopted during ‘everyone in’ for example).

The Government announced over £200 million to create Single Homelessness Accommodation Programme (SHAP), following the publication of the Rough Sleeping Strategy on Saturday 3 September 2022. This programme aims to provide up to 2,400 units of supported accommodation to address existing rough sleeping need in a local area’s pathway and help prevent future rough sleeping.

The programme will target two groups in particular: those with the longest histories of rough sleeping or the most complex needs, and vulnerable young people (age 18-25) at risk of

homelessness or rough sleeping. Capital funding will be available to financial year 2024/25, with three years of accompanying revenue funding for support services.

Somerset was identified through data as an area which has a need for further accommodation for SHAP's target groups. There is a comprehensive 2023/2024 Ending Rough Sleeping Plan for Somerset through Somerset Council Housing Services are working closely with DLUHC.

<table>
<tr><td colspan="2">The DLUHC criteria to identify the SHAP target group is:
1. People seen sleeping out in 3 or more months out of the last 12 months.
2. People seen sleeping rough again after no contact for 180 days from the date they were last seen out.
3. People housed within the previous 3 months who would have met criteria (a) or (b) prior to being accommodated.</td></tr>
<tr><td>How many people are in your Target Priority Group / Target 1000 in 2023/24?</td><td>South: 41
East: 40
North: 28
West: 27
Total = 136</td></tr>
</table>

The current Somerset Council SHAP activity in includes:

- Working in partnership with a specialist Registered Provider (RP) to develop 4/5 modular housing units in the east of Somerset. This will become intermediate supported move-on accommodation. Land has been identified and feasibility work is being undertaken to support the development, including preparation of design and layout detail for appropriate consultation with neighbours and the wider community. Both Homes England and DLUHC understand the various development issues and are working closely with Somerset Council to help deliver this much needed scheme. There is still work to do in developing the scheme; the land identified has some challenges and constraints, and which could affect the overall viability of the scheme - success is by no means guaranteed.

- Targeted Funding and RSI 2022-25 – new off the street accommodation. New off the street accommodation has opened in the east area with a 10-bed high support (24hr cover) off-the-street accommodation and assessment centre in Shepton Mallet and a 3-bed satellite premises in Frome. The 3-bed accommodation opened in June 2023 and the provider has been working with clients transitionally towards all units being fully operational by August 2023.

The Better Futures evidence led strategy will be published later in 2023 and will include significant advice and guidance for housing and services commissioners in Somerset. This will include a future commissioning intentions and proposed commissioning process/delivery plan.

5.5 Climate

The UKHSA Adverse Weather and Health Plan - Protecting health from weather related harm (2023-24) considers the health effects of adverse weather events on the population and recognises that these events have become more intense and frequent due to climate change. It reports that heatwaves in England have resulted in significant excess mortality in recent years, and that evidence suggests a risk of acute mortality increases at high temperatures in all populations. Whilst temperatures are expected to rise, the risk from cold weather will continue to contribute to significant excess mortality across England for the foreseeable future. The plan identifies people experiencing homelessness, including rough sleepers and those

who are unable to make adaptations to their living accommodation such as sofa surfers or those living in hostels as a vulnerable group of people[98]. Additionally, the climate change–homelessness nexus the authors considered in 2021 suggests that housing and shelter are pivotal in considering the physical and mental health impacts of climate change for individuals without shelter or who live in temporary and unfit housing[99].

At a local level, climate events are managed through the Severe Weather Emergency Protocol (SWEP). The protocol primarily relates to spaces opened as shelter for people sleeping rough when there is an increased risk of death due to severe weather e.g., temperatures fall near or below freezing or are very high. There is no legal requirement for Local Authorities to provide shelter for everyone during severe weather. However, it is widely accepted that there is a humanitarian obligation to provide SWEP and prevent death.

Somerset Council commissions SWEP. The accommodation provider varies depending on the local context of services and housing supply. It may be community based during a heatwave, for example, or in colder weather via B&Bs or hotels or spot purchasing of beds in shelters or hostels. Since COVID, there has been a change in approach to provision with a preference for self-contained or ensuite accommodation; – this has brought additional cost and complexity to delivering SWEP. Shared accommodation, which used to be the model used, is now discouraged[100].

The Somerset Homelessness Reduction Board has identified SWEP as an area that requires a countywide approach now that the 5 local authorities have come together. This now forms part of the wider SHAP plan being developed by SC and DLUHC. SWASFT data for Somerset indicates there is very little annual demand for Ambulance attendance due to symptoms linked to extreme weather. This may indicate that local response to cold or hot weather events meets the needs of the cohort in Somerset.

6 Key policy

The latest NICE Guidance, Integrated health and social care for people experiencing homelessness (NG214), (published 16 March 2022) recommends that commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness, and involve commissioners from other sectors, such as criminal justice and domestic abuse, as needed. These services should contribute to the government's aim of ending rough sleeping and preventing homelessness.

NG214 recognises that people experiencing homelessness often need additional resources and a more targeted service delivery to:

- ensure that resources are allocated according to need and disadvantage.
- take into account the social determinants of health
- improve long-term outcomes and address health inequalities.

Guidance also suggests that up-to-date local homelessness health and social care needs assessment is conducted, maintained and used to design, plan and deliver services according to need. It should include thorough engagement with service providers (including voluntary and charity sector service providers) and experts by experience.

Local homelessness health and social care needs assessments should:

- quantify and characterise the population experiencing homelessness or at risk of homelessness, including health inequalities, diversity and inclusion issues and specific needs and identify trends.
- assess the quality and capacity of existing mainstream and specialist service provision to inform the need for service development and investment
- assess access to and engagement with current services by people experiencing homelessness.
- identify opportunities for more integrated service delivery take into consideration relevant findings from Safeguarding Adults Reviews[101]

People experiencing homelessness are a Core 20 'PLUS' group in Somerset, which has been agreed by the Population Health Board. Implications are that the system has a responsibility to monitor and evaluate work regarding this population, where it has been identified that they experience significantly poorer and avoidable health outcomes.

Ending Rough Sleeping for Good (2022)

This strategy published in September 2022 sets out a whole system approach that puts the needs of those experiencing rough sleeping at its heart and ensures strong national and, most importantly, local leadership and accountability to deliver rough sleeping outcomes. It covers Prevention, Intervention and Recovery. The expectation is that the new local Integrated Care Systems (ICSs) take account of the health and social care needs of people sleeping rough in their area.

The strategy requires a holistic view of the problem by focusing on prevention and looking at the causes as well as the symptoms. it sets out how the system - from central government, local leaders, rough sleeping coordinators, social workers, volunteers, prison workers and housing officers – can collaborate to not only get people off the streets, but to stop them ending up there in the first place. The full report can be found at: Ending Rough Sleeping for Good (publishing.service.gov.uk).

7 Evidence Review

As discussed above homelessness is characterised by complex health and care needs often including “tri-morbidity” – with the combination of physical illness, mental illness, and substance use disorders. This Health Needs Assessment has identified two salient health outcomes in the homeless and rough sleeper population: Mental Health, and Substance Misuse – as well as dual diagnosis of both. Subsequently this literature review focuses on these topics, and effectiveness of interventions which may be used to alleviate these outcomes.

The search strategy is outlined in the appendices at the end of the document.

7.1 Substance Misuse

Substance misuse among homeless individuals is a complex issue that requires effective interventions to address the multifaceted challenges faced by this vulnerable population. This evidence review aims to assess the effectiveness of various substance misuse interventions in the homeless and rough sleeping population, based on the available literature. This will provide insight into different types of interventions and their impact on substance use outcomes, housing stability, social impact, interdisciplinary care, patient perspectives, and engagement with care.

Ecologically based treatment was effective in reducing substance use and improving housing stability among homeless mothers, in this example a systematically developed housing intervention, combined with ongoing substance abuse treatment and case management. This integrative intervention including 3 months rental/utility assistance, case management, and substance abuse counselling led to a quicker decline in alcohol use compared to treatment as usual (TAU)[102]. Case management was also considered in other evidence. Morandi et al.[103] looked at the impact of intensive case management for addiction in cases of dual diagnosis of mental health and substance abuse, which found a significantly improved treatment adherence, and substance intake/frequency of use, as well as a decrease in psychiatric emergency department visits; a reduction in homelessness was also observed, it is unclear if this is a direct outcome of the intervention.

Munthe-Kaas et al.[104] considered high and low intensity case management, finding that high intensity case management made little impact on length of time spent in stable housing compared to low intensity case management. Additionally, this review considered the impact of abstinence-contingent housing, with day treatment, when compared to TAU this can lead to fewer days spent homeless. Finally, there was consideration of non-abstinence-contingent housing such as ‘Housing First’ which increases the time in stable housing – there is no comment in this paper on the impacts of these interventions reducing substance misuse. The results showed no indication of housing programs or case management resulting in poorer outcomes for homeless or at-risk individuals than usual services.

Case management was considered as part of a broader intervention by Stergiopoulos et al.[105] in the impact of coordinated care through the CATCH program (Coordinated Access to Care for the Homeless). This interdisciplinary intervention considers case management, peer support, access to primary psychiatric care, and other community services, facilitating transitions from hospital to community care. This found that CATCH participants had statistically significant improvements in mental and physical health status and reductions in mental health symptoms, substance misuse, and the number of hospital admissions.

Continuity of care is reflected on through the use of clinical pharmacy services based at the specialist homeless healthcare[106]. This would alleviate some of the barriers people experiencing homelessness face regarding accessing medicines and healthcare, with a patient-centred approach meeting unmet needs in the homeless population. Understanding of prescribed medicines, and a holistic approach to health, (as well as correct diagnosis) may reduce self-treatment through substance misuse. Additionally, this could help to address reluctancy to be admitted to hospital due to a lack of substance misuse offering to inpatients, by assisting in referrals to find suitable places for individuals and providing continuity of care. Coordination of care in using service segmentation to better align resource to patient needs, in emergency medical services. This is aimed at patients with complex housing and substance-use disorder needs and is seen as beneficial in reducing unnecessary transport to emergency departments, there is however no outcome in this study regarding the impact on substance misuse[107].

The SHARPS study demonstrated the feasibility and potential effectiveness of a peer-delivered intervention in reducing harm and improving the mental and physical well-being of homeless individuals with substance use issues[108]. The use of peer-navigators improved service engagement, and enabled development of trusting, meaningful relationships which in turn led to largely positive outcomes in terms of reduction in substance use and engagement with services; this however needs more research to prove efficacy. Positive social impact was also discussed by Matulič-Domadzič et al.[109] who highlighted the positive social impact of psychology-based interventions on homeless populations, emphasising the importance of solidarity networks in enhancing intervention effectiveness. Strong solidarity networks were shown as fundamental in overcoming participants' homelessness and other circumstances including alcoholism and drug abuse.

Finally, pharmacological interventions such as supervised consumption facilities were found to reduce overdoses and improve access to care, managed alcohol interventions/programs stabilised or reduced alcohol consumption, and pharmaceutical interventions reduced harm, substance misuse, and mortality. The evidence used in this review however is generally of low quality, and more research would be needed, especially on the use of manage alcohol programs[110].

The reviewed evidence, which includes some studies conducted outside of England and Wales, suggests that a variety of interventions can be effective in addressing substance misuse among homeless individuals. Ecologically based treatment, solidarity networks, designated EMS teams, peer-delivered interventions, supervised consumption facilities, managed alcohol programs, pharmacological agents, brief interdisciplinary interventions, clinical pharmacy interventions, and intensive case management have all shown promise in improving; substance use outcomes, housing stability, social impact, patient perspectives, and engagement with care. However, further research is needed to determine the long-term effectiveness, cost-effectiveness, and scalability of these interventions in diverse settings and populations.

7.2 Mental Health

As considered above homelessness and rough sleeping is a complex social issue, which often intersects with poor mental health. Individuals experiencing homelessness face multiple challenges that can negatively impact their mental well-being. Mental health interventions play a crucial role in addressing the unique needs of this population. This evidence review aims to assess the effectiveness of mental health interventions in the homeless population.

Non-pharmacological interventions to improve social circumstance such as Housing First was a common approach discussed in the papers. Interventions improving homelessness, such as

Housing First, suggest high-intensity interventions with comprehensive multidisciplinary support can facilitate positive change in social circumstance for people with mental health conditions[111].

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness. This does not require individuals to address all health and behavioural variables impacting housing. Housing First versus TAU studies found mixed effects on the outcomes. Housing First approaches were found to improve self-reported mental health but did not make a statistically significant difference[112]. Similarly, O'Campo et al.[113] found social and mental health outcomes were similar for both intervention and TAU at 6-, 12, 18- and 24-months post-enrolment. Women in the intervention group did, however, spend longer in stable housing. Aquin et al.[114] failed to find any evidence that Housing First was superior to TAU in reducing suicidal ideation. The study comments on the importance of relevant training and tailored interventions, equipped to address the unique risk factors of those experiencing homelessness to prevent individuals with suicidal thoughts or behaviour being directed to emergency services. Additionally, mental health symptoms and rates of alcohol or substance dependence were not found to be changed by Housing First (this did however reduce inpatient days and improve housing stability among homeless people with severe mental illness)[115].

Housing First when combined with other factors may be more effective. Housing First interventions with ACT (Assertive community treatment) had no effect on hospitalisation rates in homeless adults with a high need for mental health services but did reduce number of days spent in hospital and ED admissions[116]. This contrasts the findings of Mejia-Lancheros et al.[117] in which Housing First with ACT led to a significant decrease in primary care visits for homeless adults with a high need for mental health services.

Permanent supportive housing (PSH) was found to decrease psychiatric ED visits and shelter use, as well as increasing outpatient mental health care, but not medical ED visits or hospitalisations[118]. Moledina et al.[119] carried out a review which presents that the majority of PSH studies found no significant benefit on mental-health or substance-use outcomes. This study also presented other forms of interventions including income assistance (which led to short-term improvement in depression and perceived stress but no evidence of long-term impact on mental health), and other mental health interventions including: ICM - intensive case management, ACT - assertive community treatment and CTI - critical time intervention. These appeared to reduce the number of days homeless and had varied effects on psychiatric symptoms, quality of life, and substance use over time.

Role-based interventions, defined by the introduction of a new role, position or job title in addition to treatment as usual, were found to have no significant impact on mental health in homeless individuals being discharged from acute mental health care. Peer support led to no statistical changes in hope or quality of life for individuals, nor did Transitional Discharge Model (aiming to increase continuity of care from hospital to community)[120]. A collaborative care model, used to address the needs of homeless mothers, found that more women in the intervention group reported ≥50% improvement in depression symptoms at 6 months compared to usual-care women, as well as those in the intervention being more likely to receive depression treatment, and anti-depressants[121]. Collaborative care was also discussed by Murray et al.[122] in terms of ensuring complex needs of the population are catered to and individuals are supported to overcome barriers which may prevent access to services. This review acknowledges a significant gap in the evidence of suicide specific prevention interventions targeting people experiencing homelessness.

Other considerations also arise in the included literature. Short-term shelter-based mental health service found that the three core aspects most beneficial to recovery were: 1) community-based and flexible – enabling continuity in routine, 2) secure environment, 3) a multimodal mental health and social service approach. Removal of some pressures of homelessness and the opportunity for flexible mental healthcare, found that participants engaged in developing treatment plans, and symptoms of mental illness were alleviated[123]. Supporting basic needs such as food insecurity, as well as mental health services was also found to improve health and well-being in the homeless population, this however was based on a small sample[124]. Emotional regulation skills can help reduce distress related to psychotic symptoms and maintain abstinence in substance use disorders. Mobile interventions such as apps can be utilised to improve access to these technologies – this however is reliant on the assumption that individuals will be able to access this[125].

Many of these studies have limitations, including small sample sizes and needing more research to understand causal relationships. However, interventions and services aimed to enhance resilience mechanisms and strategies are warranted to enhance better mental health and quality of life outcomes of this population group.

8 Services and Funding

The current approach to service provision and funding for homelessness health in Somerset has been responsive to need and developed organically over time. Since 2018 the approach has been led by tactical experts from across the system working closely together to apply best practice and implement policy and guidance (such as NG214) but without a clear overarching strategy in place.

Some funding has come from long-term (CCG/ICB) commissioning via PCNs, other funding has been through NHS pilot activity which has been adopted into business as usual (this is an ongoing process) and other activity has been funded through time-limited funding, received via the NHS Covid Vaccine programme and COMF.

The current offer has been recognised nationally at both the Royal Society for Public Health Awards 2022 (Health Equity category) and more recently at the NHS Parliamentary Awards 2023 (Health Equity category).

Those delivering 'the service' operationally have been approached to present at regional and national forums where details of their approach and insight have been sought by others.

The current core offer comprises; Specialist GPs and Homeless Rough Sleeper Nursing Service.

Services provided include:

- Basic Health Checks
- Wound care
- Blood tests including Hep C/Hep B/HIV testing/ Syphilis testing.
- Help with Medical Appointments
- Advice and support with medication concerns
- Sexual health promotion, contraception advice and STI checks
- Dental health promotion
- Swabs, removal of stitches/staples
- Confidential advice/ advocacy
- Care co-ordination
- Safeguarding

In addition to the core offer described above, Somerset has also been identified for and sought additional funding to deliver:

Specialist Mental Health provision – NHSE funding as part of the NHS Long Term Plan for the mobilisation of specialist Mental Health outreach provision - provision which, post pilot, will become part of the baseline NHS offer in Somerset. The funding has been deployed by the ICB to the HRSNS and enabled the recruitment (April 2023) of:

- 2 x B6 Mental Health Nurses
- 2 x B3 Peer Support Workers

Rough sleeping drug and alcohol treatment grant – funds local areas to implement evidence-based drug and alcohol treatment and wrap-around support for people sleeping rough or at risk of sleeping rough, including those with co-occurring mental health needs. There is also an inpatient detox and residential rehabilitation element to the funding allocations.

The fund is overseen by Department for Levelling Up, Housing and Communities (DLUHC) and the Office for Health Improvement and Disparities (OHID) and in 2022 Mendip was an area of Somerset identified as one of the additional Local Authorities to receive this grant as part of Phase 3 of the programme.

The funding is routed through Somerset Council and the plan is to establish a team of specialist drug and alcohol staff who work alongside existing practitioners locally and in particular the HRSNS and Outreach GP's. This will be a sub-team within the commissioned Somerset Drug and Alcohol Service (SDAS) so it can draw on the wider service's expertise.

From 1st April 2023 this funding has increased to cover the whole of Somerset since local government re-organisation. The model for the team is a team of eight consisting of: 2 nurses (non-medical prescribers- NMP), Team Leader, x 2 Advanced Practitioner and x 3 Recovery Workers. Working on an East (former Mendip and South Somerset) and West (Somerset West and Taunton and Sedgemoor) geographical split with capacity to move as demand/need requires. The funding is confirmed to March 2024 under a Memorandum of Understanding (MOU) and likely to continue into 2024/25 with a further MOU.

Dentistry/Oral Health – NHS Funded Pilot to deliver targeted dental services for inclusion health groups.

Working with a Consultant in Dental Public Health, based at NHS England South West, Public Health, NHS and VCSFE partners in Yeovil have come together to complete the time limited funded approach to deliver targeted dental services to vulnerable adults (primarily people experiencing homelessness). This will be a combination of primarily acute/urgent care with some additional restorative work delivered via a local referral pathway. This pilot commenced in August 2023.

Known 'Gaps' in provision:

Partners locally, regionally and nationally are engaged in activity to meet the health needs of those experiencing homelessness in Somerset. Despite this and the success of local activity there are still gaps at both operational and system level regarding provision, treatment, training and oversight which still need to be developed locally.These gaps include:

- **Dual Diagnosis**

Complex Care Team approach; Operational managers believe there is significant merit in developing a Complex Care Team approach, under the MEAM principles, for those patients facing multiple disadvantage (which creates complexity in care planning and support). This would be a multi-disciplinary team with a caseload working with services, including mental health services, SDAS, health, homeless nursing, Second Step, housing outreach, SIDAS, ASC and safeguarding.

"Patients we see currently have so many teams involved, not always communicating well, all with different agendas, asking patients to be in different places on the same days and getting discharged via non – engagement all using different information systems. I aspire for multi-agency MEAM team at the top of the system chain that other services could refer into when all their attempts are failing in existing models" Dual Diagnosis practitioner.

Development of a treatment housing offer in Somerset, i.e., an offer for those with treatment focus occurring inside the accommodation settings rather than just provisions being tolerant of it (See below).

- **Treatment and Supported Accommodation, and Accommodation which is tolerant of those experiencing multiple disadvantage.**

The SHAP, wider Better Futures work and the approach taken to SWEP by the new Somerset Council should all impact on the accommodation offer and particularly that intended to meet the needs of those with the longest histories of rough sleeping or the most complex needs, and vulnerable young people (age 18-25) at risk of homelessness or rough sleeping. The Better Futures Commissioning Plan will be subject to approval by the HRB in Autumn 2023.

There will be a corresponding need to ensure that there are sufficient appropriately trained accommodation and specialist health and social care staff to meet the needs of those adults with multiple complex needs including self-neglect who enter accommodation. Access to housing and health care cannot be conditional on abstinence and there will need to be national policy and legislative changes to enable the adoption of evidence led innovated approaches to this[126].

- **Safeguarding and Self-neglect**

NG214 states that Safeguarding Adults Boards should;

- ensure that specific reference is made to people experiencing homeless in their annual reports and strategic plan.
- share recommendations and key learning related to homelessness from Safeguarding Adults Reviews with key stakeholders
- establish ways of analysing and interrogating data on safeguarding notifications about people experiencing homelessness so that they can check that local safeguarding arrangements offer the necessary protection.
- should support health and social care staff to understand and apply laws relevant to people experiencing homelessness and who are in need of safeguarding. This should include ensuring that they can recognise signs of abuse and neglect (including self-neglect) and how to make a safeguarding referral.

- **Homeless Mortality Reviews**

In July 2023 the Independent Chair for the Somerset Safeguarding Adults Board (SSAB) agreed to support the development of a Homeless Mortality Review process in Somerset. This will need system wide support and the final proposal will be put before the SSAB, Homeless Reduction Board and finally the Somerset Board (See 3.10 Deaths of Homeless People – above).

9 Recommendations

1. **ICB** to develop an overarching **Somerset Homeless People's Health strategy** to underpin the Somerset ICS's NHS Core 20 Plus commitment where homelessness has been identified as a system priority and adopt the principles for NHS Inclusion Health – once published.
2. **Accommodation and support** – Housing (Somerset Council) and Health (NHS) to collaborate with partners on the delivery of strategy, including outreach, residential provision, and a hospital pathway.
3. **Care coordination** and **continuity of care** between settings - including better access to patient data (where practitioners can view and update data which can be seen across health and care organisations).
4. **Mental Health** – system leaders and commissioners to acknowledge the scale of the findings around mental health and consider impact of this on future commissioning – e.g., Better Futures etc.
5. **Substance misuse** – Somerset Strategic Drug and Alcohol Partnership to review and develop local pathways for inpatient detoxification and residential rehabilitation and build links with housing to develop step down options to prevent homelessness after an acute episode leading to hospital admission.
6. **Health Protection** - Prevention, detection and treatment of infections related to injecting drug use - health and care partners to collaborate on improving the data around HVC, HIV, iGAS etc. to ensure coordinated and targeted activity to improve case finding and reporting and engage clients in prevention and treatment.
7. **Dental Access** – The outcomes/findings of the time limited homeless dental access pilot will need to be considered and the learning incorporated into the wider Somerset Homeless People's Health strategy to inform future approaches and funded activity.
8. **Prevention activity** – Housing, Children's Social Care and Education (School/FE) workforce development regarding the long-term impact of ACEs and trauma and the need for all practitioners to both see and act.
9. **PCN/SFT (Emergency Dept.)** mandatory education programme around inclusion health and multiple disadvantage – service leads and patient facing staff (adopt the principles for NHS Inclusion Health – once published).
10. **Adults Social Care**
    a. education programme around self-neglect, executive dysfunction and Care Act legislation – commissioners and operational staff.
    b. Need for improved data recording – e.g., housing status within Eclipse.
    c. Improved locality working
11. **Safeguarding -** Somerset Safeguarding Adults Board, Somerset Council and NHS to adopt and implement NICE Guidance NG214.
12. **Homeless mortality, Coroner, Medical Examiner** - Improved approach to recording, reviewing and understanding deaths amongst the cohort.
13. **Annual data refresh to track progress** – NHS, SWASFT, Temporary Accommodation, and coroner (as seen in this report).

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11 Appendices

Appendix 1 – Somerset Drug and Alcohol Service Homeless Data Analysis.

The information is based on adult clients who began tier 3 structured treatment with Somerset Drug and Alcohol Service (SDAS) between April 1, 2020, and March 31, 2023. On an average, during these three financial years, the number of adult clients who began treatment with SDAS was 1351. SDAS uses specific definitions for housing status as per the national dataset - NDTMS (National Drug Treatment Monitoring System), and below are the specific definitions that relate to analysis in this report.

NFA-Urgent housing problem: Lives on streets/rough sleeper, uses night shelter (night-by-night basis)/emergency hostels, sofa surfing/sleeps on different friend's floor each night.
Housing Problem: Staying with friends/family as a short-term guest, night winter shelter, Direct Access short stay hostel, short term B&B or other hotel, placed in temporary accommodation by Local Authority, squatting.
No housing problem: Owner occupier, tenant – Private landlord/Housing Association /Local Authority/Registered, landlord/arm's length management organisation, approved premises, supported housing/hostel, traveller, own property, settled mainstream housing with friends/family, shared ownership scheme.

This information is collected at assessment when a client starts their treatment.

1. Of those who are identified as having Housing Problem or NFA and coming into the service for treatment for alcohol, drugs or both:

(a) who refers, The most common source of referrals of adult clients coming into the treatment are self-referral, followed by referrals from CARAT/prison, other sources (via a pathway which falls out of the main groupings defined by the National Drug Treatment Monitoring System), and then Children's Social Care, the national Probation Service, and general practitioners (GP). While there are other referral sources, they make up a very small percentage, for example Domestic Abuse Service, NHS health checks etc.

Main referral Source	Percentage of clients
Self	57.36%
CARAT/Prison	16.71%
Other	5.14%
Children's Social Care	4.56%
National Probation Service	3.04%
GP	1.75%

(b) what are the obstacles to treatment, The service commissioned allows for self-referral and people can make that referral either by phone, online or direct through the SDAS outreach team. This sub team has two priorities: homeless people especially placed in hostels and supported housing services and the acute hospitals. In this latter situation, SDAS in-reach to the hospitals, especially Emergency Departments. There are staff as part of the Young People's and Families Team who work Friday and Saturday nights – 7pm to 3am – in both Musgrove Park and Yeovil hospitals Emergency Departments. This team specifically target those under 25 years attending but will identify and engage with any age where drugs and/or alcohol is a factor in the attendance. The fact that someone is homeless and/or rough sleeping is not conducive to engaging in treatment, as being without safe and secure accommodation is in itself a barrier to staying in treatment.

(c) whether treatment timelines are similar to the non-homeless cohort.

Clients who have been identified as NFA or housing problem, the treatment timeline i.e., duration between the start of their treatment journey until their discharge from service as *treatment completed-drug free, treatment completed -alcohol free or treatment completed-occasional user (not heroin and crack) is relatively higher, when comparing with those who have no housing problem.

According to the guidance set by NDTMS, substances are classified into the following categories, rather than drug, alcohol, or both.

- Alcohol and non-opiate
- Alcohol only
- Non-opiate only
- Opiate

Clients who use opiates, regardless of other substances used, are categorised under the opiate group. In other words, a client who use opiates may use other substances as well and would, in terms of data collection, be indicated as part of their use – 1st 2nd and 3rd substance used.

The table below presents the average treatment timeline (in days) for clients, discharged as *treatment complete" by housing status, and substance categories.

Accom Need	Alcohol and non-opiate	Alcohol only	Non-opiate only	Opiate	**Total**
Housing problem	150.58	154.57	140.52	284.00	**161.69**
NFA - urgent housing problem	123.50	162.12	114.45	313.93	**182.59**
No housing problem	140.56	128.24	116.13	239.23	**137.45**
Total	**141.01**	**130.67**	**119.52**	**251.14**	**141.33**

The data indicates that clients who entered treatment and who had an urgent housing problem tend to have a longer treatment duration, especially for opiate clients.

(d) whether any of those clients have other health needs

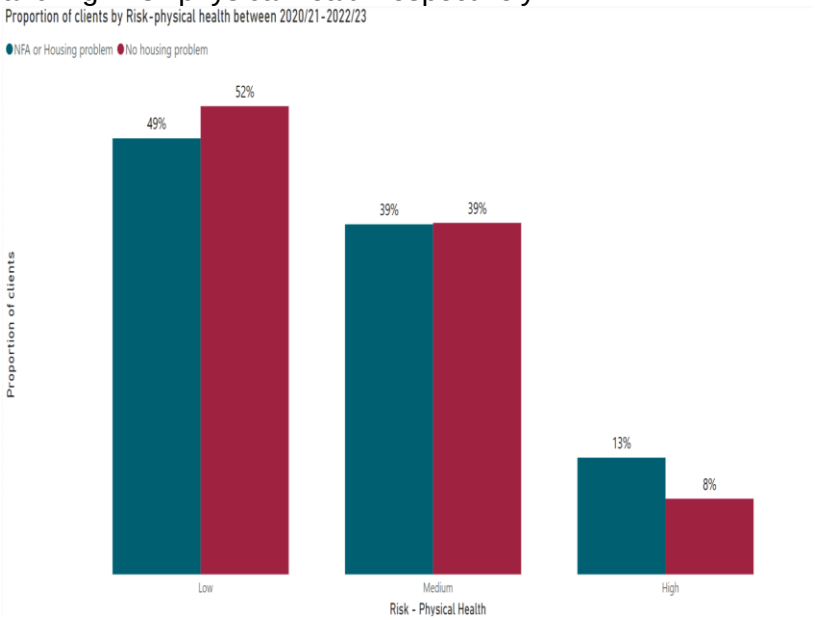
d1 Proportion of clients who entered treatment during 2020/21-2022/23 by disability.

Disability	Proportion of clients
No disability	52.09%
Behaviour and emotional	17.16%
Not stated	11.44%
Mobility and gross motor	5.48%
Progressive conditions and physical health	5.01%
Learning disability	3.93%
Other	2.98%
Personal, self-care and continence	0.60%
Hearing	0.48%
Sight	0.48%
Manual dexterity	0.36%

Among those who are NFA or housing problem, 52% of adult clients do not have any disability, while 17.16% report behaviour and emotional disabilities and 5.5% are identified with mobility and gross motor impairments. These are their primary disabilities; they may have additional disabilities. Under NDTMS a person can record up to 3 disability categories.

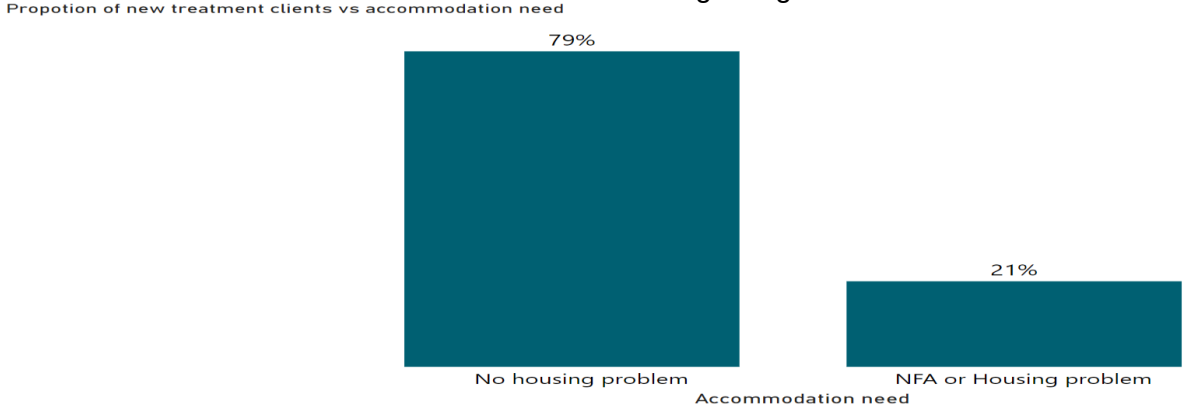
Please see the link below, this explains how the various definition of disabilities recorded under NDTMS:
https://www.ndtms.net/resources/public/Event%20and%20Training%20Documentation/CDS-Q/NDTMS%20Adult%20drug%20and%20alcohol%20treatment%20business%20definitions%20V15.3.pdf

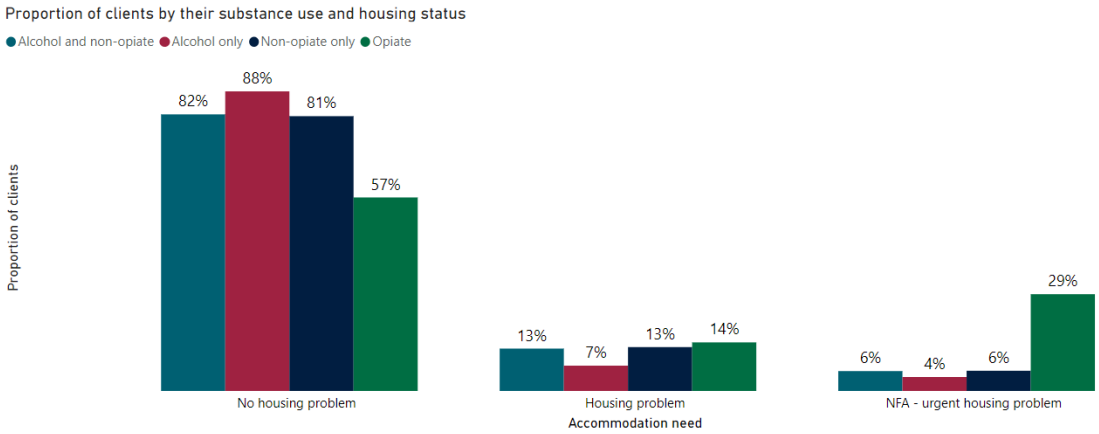
d.2 when a person enters treatment, alongside their assessment of need, there is a risk assessment which seeks to understand a whole range of risk factors including risks linked to physical health and wellbeing as well as mental health.
Of those who were identified as having Housing Problem or NFA and coming into the service for treatment, 49% of clients assessed as being low risk-physical health, while 39 % and 13% as medium and high risk- physical health respectively. For the cohort with no housing problem, 52% of clients being assessed were low risk physical health while 39% and 8% as medium and high-risk physical health respectively.



(2) What proportion of the total client group is made up of those with a Housing Problem or NFA and whether this for alcohol, drugs, or both (It looks for example like 37% of the non-alcohol using client group is vulnerably housed or NFA – are these drugs only clients?) – and where there is comorbidity how does this change?

Between 2020/21-2022/23, 21% of the total adult clients entering treatment have been identified as either NFA or housing problem. In the charts below we have looked at housing status and substance in line with the four NDTMS drug categories.





From the data of those accessing treatment we can see that proportionately alcohol only using adult clients are less likely to have a housing problem than other substance groups. Clients using opiates are highly likely to have housing problem or NFA. Analysing data from the past three financial indicates that 43% of opiate clients that came to structured tier 3 treatment had NFA/housing problem, while 19% alcohol and non-opiate clients had NFA or housing problem.

(3) Of the Housing Problem or NFA group how many reports also having mental health needs – and of those how many being in receipt of treatment? Somerset FT NHS data (Musgrove) shows that the dominant disclosed health need for the wider 'homeless cohort' is mental health, yet this is the area with the least specialist staff working in the realm of homeless health.

At the start of treatment episode with SDAS the following information is collected and recorded.

- Does the client have a mental health treatment need?
- Whether the mental health problem identified by a mental health professional (dual diagnosis)
- Are they in contact with mental health services?
- Is the client receiving treatment for their mental health need(s)

The answers will be recorded as per the NDTMS guidelines. Please see the link below to see page 63/64 how it being recorded: NDTMS - Adult drug and alcohol treatment business definitions CDS-P (V14.3) (publishing.service.gov.uk)

68.8% of those clients who have been identified with housing problem or NFA has a mental health need.

Client has a Mental Health Need	NFA or Housing problem	No housing problem
No	31.15%	36.12%
Yes	68.85%	63.88%

64.7 % of clients within housing problem or NFA client group who have identified as having mental health needs are receiving treatment for their mental health.

Receiving Treatment for Mental Health	Percentage of clients
Not receiving mental health treatment	35.32%
Receiving mental health treatment	64.68%

(4) What is the impact of Housing Problem or NFA on the successful completion of treatment (or not) or the frequency of episodes engaging with the service.

Treatment journey	NFA or Housing problem	No housing problem
Incomplete treatment journey discharge	66.38%	45.81%
Treatment completed discharge	33.62%	54.19%

Of those who have housing or NFA problem, the percentage who leave treatment as treatment complete is 33.6%; while the treatment completes for individuals that have no housing issue is 54%. On the other hand, we see high proportion of adult clients with NFA, or housing problem are more likely to have an incomplete treatment journey.
NDMTS are introducing a new metric which will measure progress in treatment and success in treatment. We are not able to report locally yet. but the focus is shifting towards recognising the progress in treatment or reduced use of problematic substances rather than just looking at the successful discharge from the treatment for determining the successful treatment completion. Housing will be one of the determinants in this, so that someone cannot be discharged as successfully completing treatment if their housing situation remains problematic.

(5) Are you able to articulate the patient cost for this cohort in comparison to those with 'No housing problems?

See the Dame Carol Black Report and, in particular, the section on housing:
https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Currently for each £1 spent on treatment the system will save £4 from reduced demands on health, prison, law enforcement and emergency services.

(6) Finally for the Housing Problem or NFA group what particular gaps exist currently and/or tailored interventions are in place or being considered (i.e., you have identified a gap and been able to find or trial a solution) – such as the Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) activity?

The RSDATG is a specific additional national grant to local area introduced in phases. It started to be rolled out in 2020/21 bringing in areas in phases - Somerset is in Phase 3 which began 2022/23. Initially OHID/DLUCH identified Mendip DC as the focus – the reason why was never explained. A proposal under their templates was submitted and approved with clarification that Somerset was to become a unitary authority from 1st April 2023. Only 1 post was appointed under the Mendip only model. This postholder later resigned and so delivery did not progress. From January 2023 a proposal was made to OHID colleagues to use funding to bring on early the model for a countywide team, who would work alongside existing geographic (old districts) rough sleeper teams and SFT homeless health team, plus SDAS core service outreach team. Proposing Team of 8 FTE workers: RS Manager (nurse), Outreach Non-Medical Prescriber (NMP), Team Leader, x 2 Advanced Practitioner and x 3 Recovery Workers.

Working on East/West geographical split with capacity to move as demand/need requires. There is preparatory work that needs doing:

- Mapping need with district rough sleeper teams and others already working.
- To set a draft operating model for how it will all work as one team with partners (so a person only tells story once)
- To get the information sharing protocol agreed

- To start exploring and developing treatment pathways for people experiencing rough sleeping so that they have rapid access to prescribing, medical reviews, and inpatient care as needed.

There is a prescribed additional dataset for use of this grant which to fully respond to requires a joined-up approach by all services. It is especially important that working together people do only have to tell the story once rather than repeating it and that the services co-ordinate and work as multi-disciplinary team to support people to achieve their outcomes.

Housing status in this includes a specific definition of rough sleeping as follows:
Cohort 1: At-risk of rough sleeping - People who are at risk of rough sleeping in the area. This is down to local determination but is likely to include people who are at risk of rough sleeping because they are in: unstable or unsafe accommodation, sofa surfing, in short term or emergency accommodation, such as hostels, shelters and bed and breakfast or other forms of emergency accommodation set up in response to events such as the COVID-19 pandemic, presenting to the local housing authority as being homeless or at risk of homelessness.

Cohort 2: Rough sleeping - The DLUHC definition of rough sleeping is: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or “bashes” which are makeshift shelters, often comprised of cardboard boxes)

NDTMS business definitions:
Referral source other: The total number of individuals referred to treatment in the reporting period via a pathway which falls out of the main groupings.
Treatment completed – drug free: The client no longer requires structured drug (or alcohol) treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine or any other illicit drug.
Treatment completed – alcohol free: The client no longer requires structured alcohol (or drug) treatment interventions and is judged by the clinician to no longer be using alcohol.
Treatment completed – occasional user (not heroin and crack): The client no longer requires structured drug or alcohol treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine. There is evidence of use of other illicit drug use, but this is not judged to be problematic or to require structured treatment.

Report produced on - 12/06/2023.

Appendix 2 - Somerset Better Future Analysis – Support needs by severity, breakdown by gender

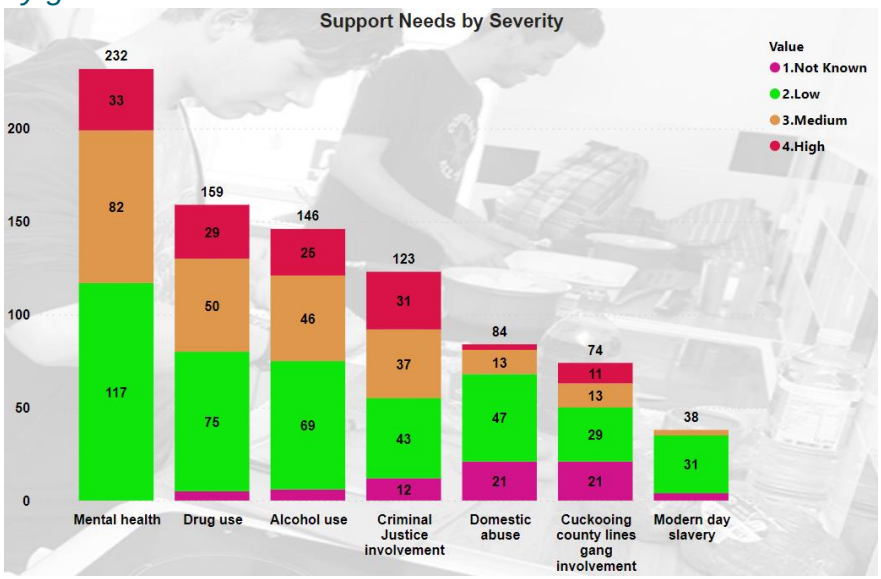


Figure 39 – Support needs by severity, Males

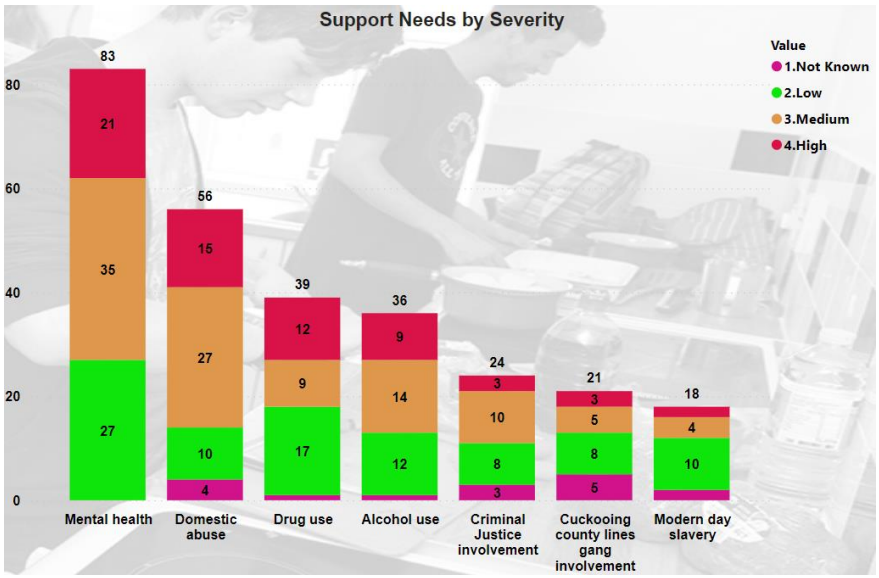
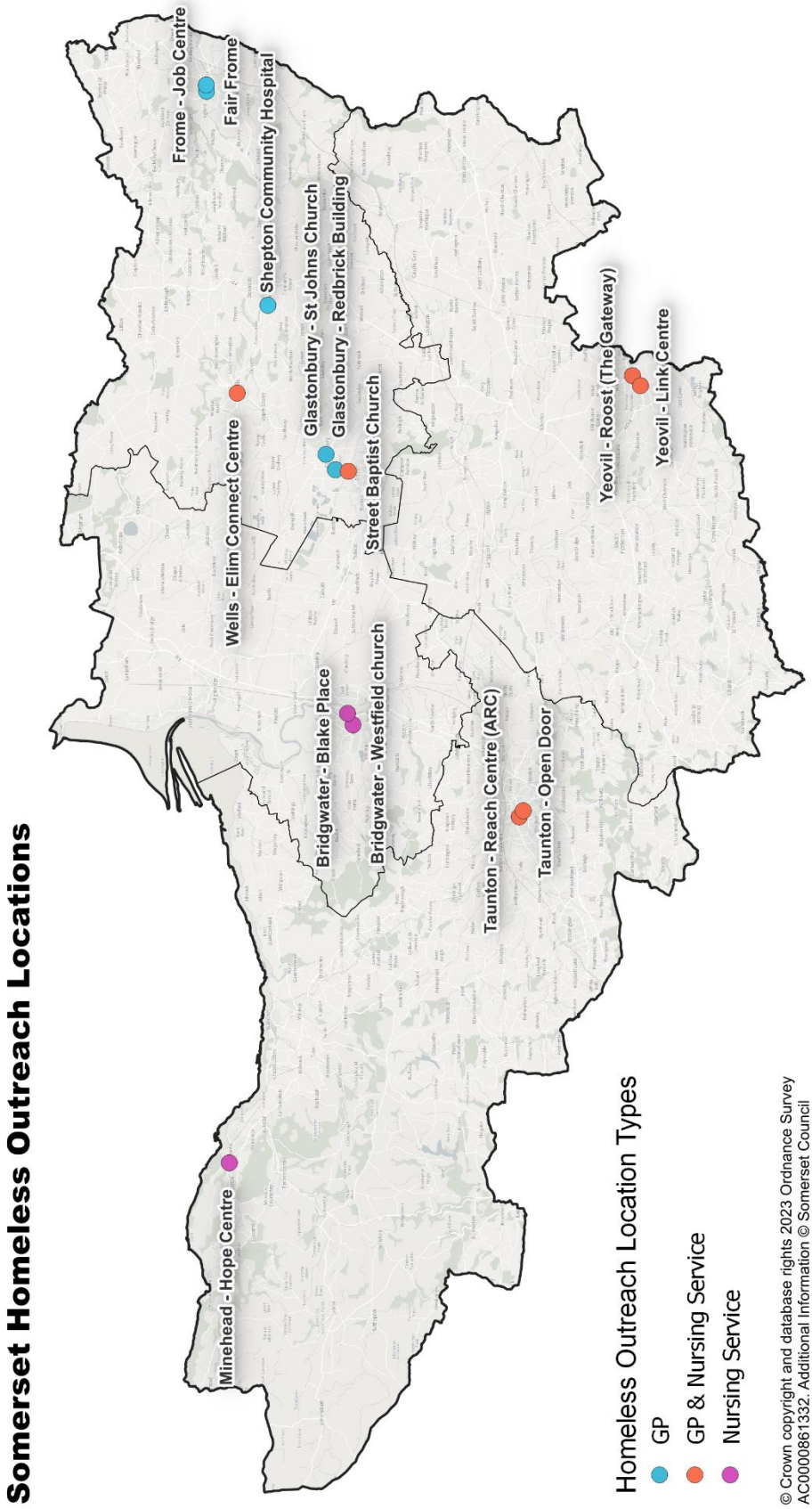


Figure 40 – Support Needs by severity, Females

Appendix 3 – Map of Homeless outreach locations across Somerset



Appendix 4 - Categories of support – P2i and better future analysis

High Support

- Young people who have complex needs requiring a high level of oversight and support (often a multi-agency approach) in a safe and supportive environment that has support staff on site 24 hours a day.
- Young people in high support services are likely to be vulnerable to exploitation (and to risks created by others), may create risks for other vulnerable young people and may struggle to consistently engage with services.
- They may have significant emotional, behavioural and/or mental health issues and are likely to need considerable support in one or more of the following:
    - Offending behaviour with a significant impact on them and wider community
    - Drug/alcohol dependency or high use
    - Life skills/tenancy skills development including challenges in keeping themselves and others safe.
    - Education, training or work, where they may face significant barriers to success.

Medium Support

- Young people who have some support needs, and will benefit from being in a safe and supportive environment that has a regular support staff presence but not 24 hours a day.
- They will need regular support, access to staff support in times of crisis (which will sometimes be outside core staffed hours) and some staff visits overnight.
- Young people in medium support services will need some support around issues such as:
- Emotional, behavioural and/or mental health issues
- Offending behaviour (though not at a level that impacts significantly on the wider community)
- Drug and alcohol use which presents a risk of increasing without input.
- Life skills/tenancy skills development
- Working towards securing education, training or employment opportunities (likely to need some support in maintaining them)

Low Support

- Young people who would benefit from a safe and supportive environment but have sufficient life skills and resilience for that accommodation to be unstaffed.
- They may need access to staff support in times of crisis and will require some keyworker support as well as regular support staff visits to the accommodation and some staff visits overnight.
- They will benefit from the opportunity to practice, and further develop, their life skills, tenancy skills, emotional resilience and confidence as they move closer to independence and will usually be able to:
    - Pursue education, training or work.
    - Manage their mental health, physical health and drug or alcohol use (perhaps with help from community resources
- Be able to manage relationships, conflict and their behaviour in accommodation and the wider community.

Appendix 5 - Homelessness Assessment – Total number of households owed a prevention or relief duty (per 100,000), by health history – for Somerset districts.
SHARE - Preventing Homelessness (homelessnessimpact.org)

Figure 41 – Somerset West and Taunton – SWAT - Homelessness Assessment – Total number of households owed a prevention or relief duty (per 100,000), by health history.

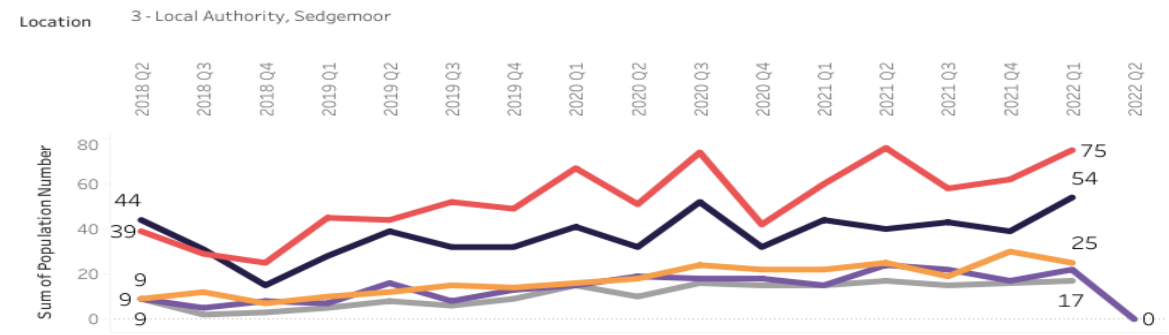


Figure 42 – Sedgemoor Homelessness Assessment – Total number of households owed a prevention or relief duty (per 100,000), by health history.

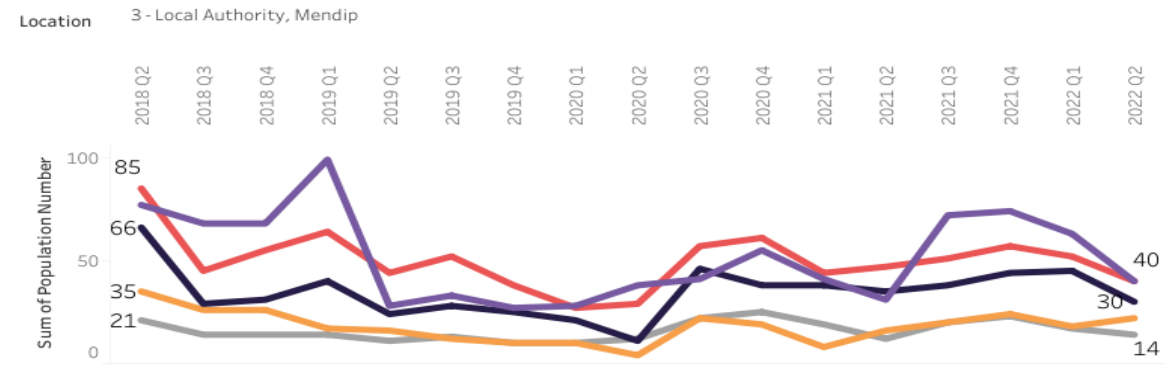


Figure 43 – Mendip Homelessness Assessment – Total number of households owed a prevention or relief duty (per 100,000), by health history.

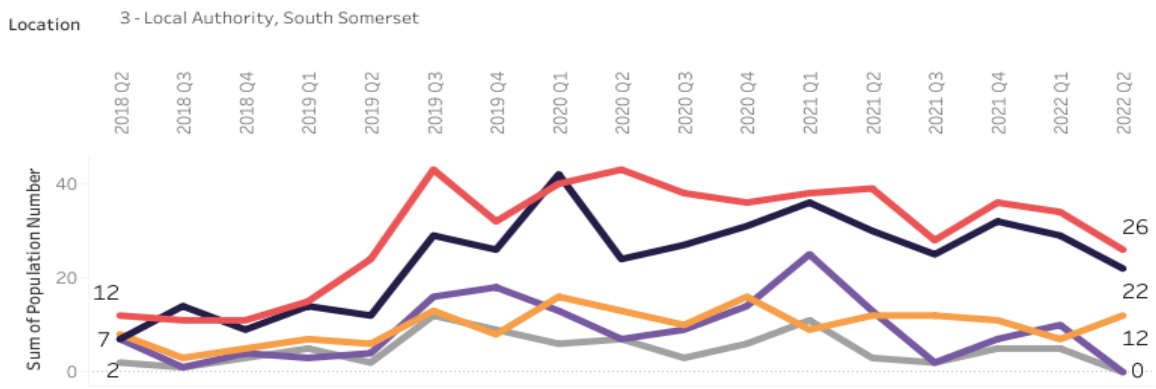


Figure 44 -South Somerset Homelessness Assessment – Total number of households owed a prevention or relief duty (per 100,000), by health history.

Appendix 6 - Search Strategy:

Inclusion: regarding homelessness, HIC, substance abuse, mental health, dual diagnosis, adults, in the last 10 years, written in English, free full text

Exclusion: LMIC, not homeless, rough sleeping etc. not regarding topic of relevance (as above), books, over 10 years old, children/youth

Search Strategy: The search focuses on the salient topics from the outcomes section of the health needs assessment. This identified mental health, substance abuse and dual diagnosis of mental health and substance misuse.

Searches were carried out using PubMed, based on the search terms below. Due to time and resource constraints, the search was based solely upon the results from PubMed, as this provided a suitable number to review – however this is not an exhaustive search.

Excluding papers based on these categories, and only utilising PubMed may have an effect on the results and synthesis of this evidence, and it is acknowledged that this is not an all-encompassing evidence review.

Search Terms:

Mental health:

(((homeless*[Title/Abstract]) OR (Rough sleeping [Title/Abstract])) AND (intervention [Title/Abstract]) AND (mental health [Title/Abstract]))

- 181 results in last 10 years

Substance misuse:

(((homeless*[Title/Abstract]) OR (Rough sleeping [Title/Abstract])) AND (intervention [Title/Abstract]) AND ((substance abuse [Title/Abstract]) OR (substance misuse [Title/Abstract])))

- 41 results in last 10 years

Initial searches returned 222 results based on the criteria above, once these were screened based on the title/abstract against the inclusion criteria this was reduced to 42.

Core reasons for exclusion

- Mental Health – no intervention present, not regarding homelessness/rough sleeping, not mental health related, duplication
- Substance misuse – not regarding substance misuse/abuse, no intervention present, not regarding homelessness/rough sleeping

Table 12 – results of searches

	Mental Health	Substance Misuse	Total
no. results produced by initial search	181	41	222
no. results left when screened on title/abstract	29	12	41
No. results after full read	15	9	24

Quality of Evidence

The evidence has been ranked based on quality using the hierarchy of scientific evidence as seen below:

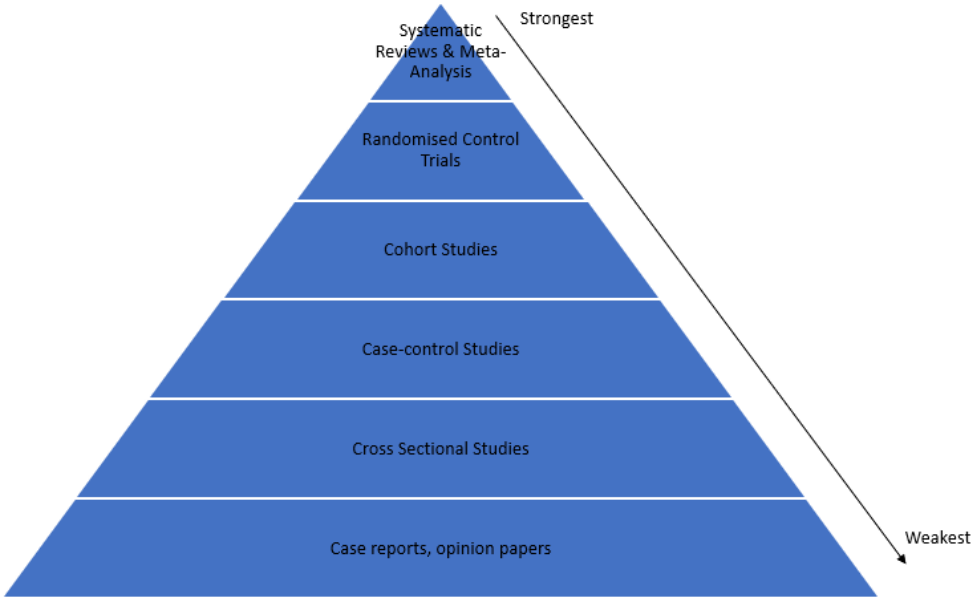


Figure 45 - The hierarchy of Scientific Evidence Source – Greenhalgh (1997)

This is summarised in the table below:

Table 13 - Quality of the literature review evidence

Quality of Evidence/**Topic**	**Mental Health**	**Substance Misuse**
1 - Meta analysis & systematic reviews	4	2
2	6	
3	4	6
4		1
5		
6 – Case reports, opinion papers,	1	